Short Doyle / Medi-Cal Claims Processing System

Health Insurance Portability and Accountability Act (HIPAA) Trading Partner Agreement

Companion Guide for the 837 P, 837 I and 835 Transactions and Code Sets

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DOCUMENT CONTROL SHEET

Approvals

Date	Name	Signature
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Date	Author	Version	Change Reference
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Date	Name	Title
3/11/2004	David Hartson	Business SME
3/11/2004	Sara-Jane Gilb	Business SME
3/11/2004	Julie Baltazar	Chief, Office of HIPAA Compliance
3/11/2004	Gary Renslo	Acting CIO Information Technology
3/11/2004	David Bass	Business SME

For questions or comments, please contact:

California Department of Mental Health
Office of HIPAA Compliance
1600 9th Street, Room 140
Sacramento, Ca 95814
(916) 654-3117

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1. INTRODUCTION

1.1. DEFINITIONS OF KEY TERMS

County – This term applies to a county or city mental health plan, or an entity that submits claims or receives remittance advice on behalf of such a plan.

SD/MC – Short-Doyle/Medi-Cal. This is the mainframe claims processing system operated by the Department of Health Services.

1.2. OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation mandates that many of the major health care electronic data exchanges, such as electronic claims and remittance advices, be standardized into the same national format for all payers, providers, and clearinghouses. All counties who submit governed data electronically to the State of California Department of Mental Health (DMH) must submit in the mandated HIPAA formats by October 16, 2003.

HIPAA specifically names several electronic transactions that must be followed when certain health care information is exchanged. These transactions are published as National Electronic Data Interchange Transaction Set Implementation Guides. They are commonly called Implementation Guides (IGs) and are referred to as IGs throughout this document. Additionally, an addendum to each of the IGs has been published and must be used to properly implement each transaction.

1.3. INTRODUCTION

This 837 companion document is provided by Information Technology and Systems Staff for Counties sending Electronic Data Interchange (EDI) 837 Transactions to DMH. This document shows how DMH uses the EDI ASC X12 837 Electronic Transaction, Versions 004010X096A1 and 004010X098A1 for compliance with the federal HIPAA of 1996.

1.4. SCOPE

The guide covers data elements that are either required or situational required to meet HIPAA validation and SD/MC processing requirements

1.5. NOT IN THE SCOPE OF THE HEALTH CARE CLAIM

Claim transactions for the purpose of the Coordination of Benefits (COB) are outside of the scope of this companion guide. Information about how a particular claim is adjudicated by DMH is also outside of the scope of this companion guide.

1.6. PRIVACY AND SECURITY PROTECTION

This companion guide does not specifically address privacy and security protection regarding the use of the system or application technology to send and receive a transaction set. For example, registration and management of users, assignment and exchange of passwords, ID, digital certificates, authentication, authorization, and other access restrictions are not addressed in this companion guide. This document assumes that the transaction exchange will take place in a processing and communication environment that is secure at both ends for the senders and the receivers of data.

1.7. PROCESSING ASSUMPTIONS

Some transactions are created and generated by, or on behalf of, a county. Others are created by DMH either in response to a request received from a county or as a means to provide pertinent information to counties or managed care organizations (MCOs). Several processing assumptions must be stated that could include inbound (to DMH) transactions or outbound (from DMH) transactions. The following list identifies each transaction by DMH definition as inbound or outbound.

DMH Transaction Definition

Inbound	Outbound
837I	997
837P	997
837I	835
837P	835

1.8. CONTACT INFORMATION

- Connectivity: David Hartson at Dhartson@dmhhq.state.ca.us or call 916.653.0736
- Claims Adjudication: David Hartson at Dhartson@dmhhq.state.ca.us or call 916.653.0736
- Translator: David Hartson at Dhartson@dmhhq.state.ca.us or call 916.653.0736
- ITWS: Please call ITWS Administration at 916.654.3117.

1.9. REFERENCE

This document supplements ASC X12N Implementation Guides that can be found at www.wpc-edi.com.

2. GETTING STARTED

2.1. COUNTIES TRADING PARTNER REGISTRATION

A biller must complete a trading partner agreement form. The trading partner agreement form is used to communicate trading partner identifiers and to indicate which transactions the biller wishes to exchange. The form is available via ITWS DMH/TP or by calling the DMH Help Desk at (916) 654-3117.

An EDI trading partner is defined as any county who transmits to, or receives electronic claims data from DMH

2.2. CERTIFICATE AND TESTING OVERVIEW

Certification from a third party is not required to exchange EDI with DMH; however, doing so can help to speed up the process of approval of the counties' transactions. A biller who wishes to send 837P transactions to DMH must pass test requirements before the biller is set up to send production transactions. Successful completion of transaction testing requires, at a minimum, that the transactions are HIPAA compliant and can be converted into the proprietary SD/MC claim format.

2.3. BASIC TECHNICAL INFORMATION

The following list includes basic technical information for each transaction:

- Lower case characters on inbound transactions are converted to uppercase on outbound transactions.
- The following delimiters are used for all outbound transactions:
  - * (asterisk) = data element separator
  - : (colon) = sub element separator
  - ~ (tilde) = segment terminator
- All monetary amounts and quantity fields have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer with the decimal point at the right end, the decimal point should be omitted. See the IGs for additional clarification.
- The TA1 – interchange acknowledgment is generated when a functional group is rejected.
- The 997 – functional acknowledgment is generated in response to all inbound batch transactions from Counties.
- If 837 file contains multiple functional groups, DMH generates multiple 997s, each corresponding to one functional group. All 997s will be placed in a single file.
- If one item within a transaction is noncompliant, the entire transaction (ST-SE) is rejected. If a file has multiple transactions (ST-SE), individual transactions may be rejected while allowing the remaining transactions to continue through processing.
- Data elements required by the IGs, but not used by DMH, must be completed with a valid value to avoid compliance errors.

3. TESTING WITH DMH

There are three levels of transaction testing required before an application is considered approved. These testing levels include the following:

- Compliance Testing
- DMH Specification Validation Testing
- End-to-End Testing

Prior to testing, any biller wanting to exchange information electronically with DMH must complete and submit a **trading partner profile** and a signed trading partner agreement. A trading partner is an entity with whom an organization exchanges data electronically. The trading partner may send or receive information electronically. For additional information about trading partner profiles, trading partner agreements, and the testing process, or to obtain copies of these documents, please contact the appropriate personnel at DMH.

A software vendor or application development organization is not required to sign and submit a trading partner agreement, but is required to complete a trading partner profile and participate in the established testing process. Once testing is successfully completed, the vendor receives written notice of approval.

To test with DMH, the appropriate **account access application** and **trading partner_agreement form** must be completed. Following the completion of these forms, DMH will notify the trading partner that they are approved to send test transactions as indicated on the trading partner agreement form. User IDs and passwords will be assigned to download and update transaction files.

Until the trading partner's 837 transactions are approved by DMH, the trading partner should submit test transaction files for testing and SD/MC edits.

Following are the steps:

1. Submit account request to ITWS test site
2. Sign and submit trading partner agreement form
3. Get user and password to access
4. Logon to ITWS test site **at https://mhhtitws.cahwnet.gov/default.asp**.
5. From **Systems** menu option, select **Short-Doyle / Medi-Cal – EOB - HFP**
6. Select **Functions** option then roll to **Upload**
7. Upload 837 file
8. 837 will be processed when uploaded to ITWS.
9. When the 997 generation is complete and ready to be downloaded, ITWS will email the partner that the 997 is waiting to be downloaded.
10. Download the 997 and check the 997 for any errors.

When the county has successfully completed the following HIPAA testing and certification procedures established by DMH:

- HIPAA Validation test for HIPAA level 5 compliance.
- HIPAA translator test by submitting 837 files with an average claim file size to ITWS.
- Completed the SD/MC process.
- County acceptance of the EOB and 835 test results.

The county notifies DMH to begin submitting HIPAA production data to the Short Doyle/Medi-Cal (SD/MC) System as outlined in the DMH Information Notice 03-10.

DMH will send the county a HIPAA production certification letter that authorizes the county to begin submitting production claims in HIPAA format to DMH.

4. 837 CONTROL SEGMENTS/ENVELOPE STRUCTURE

4.1. OVERVIEW

Appendix A, Section A.1.1 of each X12N HIPAA IGs provides details about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an electronic envelope. The communication envelope consists of an interchange envelope and functional groups. The interchange control structure is used for inbound and outbound files. An inbound interchange control structure is the envelope that wraps all transaction data (ST-SE) sent to DMH for processing. Examples include 837 and 997 transactions. An outbound interchange control structure wraps transactions that are created by DMH and returned to the requesting county. Examples of outbound transactions include 835 and 997 transactions. The following tables define the use of this control structure as it relates to communication with DMH.

4.2. SEGMENT AND DATA ELEMENT DESCRIPTION

Each segment table contains rows and columns describing different segment elements. Those components are as follows:

- Segment Name – The industry assigned segment name as identified in the IGs
- Segment ID – The industry assigned segment ID as identified in the IGs
- Loop ID – The loop within which the segment should appear
- Segment Usage – Identifies the segment as required or situational
- Segment Notes – A brief description of the purpose or use of the segment
- Example – An example of a complete segment
- Element ID – The industry assigned data element ID as identified in the IGs
- Usage – Identifies the data element as R-required, S-situational, or N/A-not used based on DMH guidelines.
- Valid values – If any value exists then that value only is expected. If the value is blank then it is the TP discretion to use an appropriate value.
- Guide Description/Valid Values – Industry name associated with the data element. If no industry name exists, this is the IGs data element name. This column also lists in BOLD the values and/or code sets to be used.
- Comments – Description of the contents of the data elements including field lengths.

4.3. ISA-IEA SEGMENTS

This section describes DMH's use of the interchange control segments. It includes a description of expected sender and receiver codes and delimiters.

Use uppercase letters in this segment.

Segment Name		Interchange Control Header	
Segment ID		ISA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		All positions within each data element in the ISA segment must be filled. Delimiters are specified in the Interchange Header Segment. The values are as follows: * Asterisk Data Element Separator : Colon Sub element Separator ~ Tilde Segment Terminator	
Example		ISA*00* *00* *ZZ*C59000000000000*ZZ*INFOTECHWEBSVCS*030918*1659*U*00401* 000000864*0*P*:	
Element ID	Usage	Valid values	Comments
ISA01	R	00	Authorization Information Qualifier
ISA02	R	10 Blanks	Authorization Information; Fixed Length
ISA03	R	00	Security Information Qualifier
ISA04	R	10 Blanks	Security Information:
ISA05	R	ZZ	Interchange ID Qualifier
ISA06	R	For County: C + County Code + 12 Zeroes, Examples: C59000000000000	Interchange Sender ID; Valid Format (Specific values defined in Trading Partner Agreements)"
ISA07	R	ZZ	Interchange ID Qualifier;
ISA08	R	INFOTECHWEBSVCS	This field has to be INFOTECHWEBSVCS
ISA09	R		Interchange Date; the date format is YYMMDD The date on which 837 is created
ISA10	R		Interchange Time; the time format is HHMM The time at which 837 is created
ISA11	R	U	Interchange Control Standards Identifier
ISA12	R	00401	Interchange Control Version Number
ISA13	R		The Interchange Control Number is created by the Sender and must have the same value as in the Interchange Trailer (IEA02). It must 9 numeric characters (e.g., 123456789).
ISA14	R	0	Acknowledgment Requested; If value were 1 = Interchange Acknowledgment (TAI01); Not currently supported 0 – No Interchange Acknowledgment Requested
ISA15	R	T or P	Usage Indicator T for Test P for Production
ISA16	R	:	Component Element Separator: The component element separator is a delimiter and not a data element. It is used with composite data elements such as CLM05.

Segment Name		Interchange Control Trailer	
Segment ID		IEA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		IEA*5*000000864~	
Element ID	Usage	Valid Values	Comments
IEA01	R		Number of included functional groups; Number of functional groups included in this interchange envelope
IEA02	R		Authorization Information same as ISA13

4.4. GS-GE SEGMENTS

This section describes the DMH use of the functional group control segments and the expected sender and receiver codes defined in the trading partner agreement. There can be multiple GS-GE segments in one ISA-IEA segments. Each GS-GE segment may contain either 837P transactions or 837I transactions, but not both.

Use uppercase letters in this segment.

Segment Name		Functional Group Header	
Segment ID		GS	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		The functional group header used for the 837 is HC.	
Example		GS*HC*C59000000000000*INFOTECHWEBSVCS*20030918*105531*5*X*004010X098A1~	
Element ID	Usage	Valid Values	Comments
GS01	R	HC	Functional Identifier Code
GS02	R	*For County: C + County Code + 12 Zeroes, Examples:* C59000000000000	Interchange Sender ID; Valid Format (Specific values defined in Trading Partner Agreements)"
GS03	R	INFOTECHWEBSVCS	Application Receivers Code
GS04	R		Date - CCYYMMDD
GS05	R		Time - HHMMSS
GS06	R		Group Control Number Must match GE02 It has to be unique within ISA segment.
GS07	R	X	Responsible Agency Code
GS08	R		For 837P: 004010X098A1 For 837I: 004010X096A1

Segment Name		Functional Group Trailer	
Segment ID		GE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		GE*5*5~	
Element ID	Usage	Valid Values	Comments
GE01	R		Number of Transaction Sets Included
GE02	R		Group Control Number same as GS06

4.5. SAMPLE INTERCHANGE CONTROL

```
ISA*00*          *00*
*ZZ*C59000000000000*ZZ*INFOTECHWEBSVCS*030918*1659*U*00401*000000864*1*P*:
GS*HC*C59000000000000*INFOTECHWEBSVCS*20030921*1659*863*X*004010X098A1
ST – 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
ST – 837 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 837 TRANSACTION SET TRAILER
GE*1*863
IEA*1*000000864
```

5. 837 PROFESSIONAL CLAIMS AND ENCOUNTERS

5.1. DESCRIPTION OF THE LAYOUT OF THE DATA

The ASC X12N 837 (04010X098A1) transaction is the HIPAA mandated instrument by which professional claims or encounter data must be submitted. As per HIPAA regulation, all electronic professional claims should be submitted using this transaction. However, for counties not yet compliant with HIPAA, DMH will continue to accept claims in proprietary format.

This document is intended only as a companion guide and is not intended to contradict or replace any information in the IGs or DMH regulations, Letters, and Notices. It is highly recommended that implementers (counties) have the following resources available during the development process:

- This document, Companion Guide – 837 Professional Claims and Encounters Transactions
- ASC X12N 837 (004010X098) and the 004010X098A1 Addenda

Additionally, there are several processing assumptions, limitations, and guidelines that a developer must be aware of when implementing the 837P transaction. The following list identifies these processing stipulations:

5.1.1 DMH has lifted restrictions accepting more than 5000 CLM segments per ST – SE. The IGs recommended creating this limitation to avert circumstances where file size management may become an issue. DMH will instead monitor the processing times for larger claim files to ensure maximum translator performance.

5.1.2 All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer, decimal point at the right end, the decimal point should be omitted. See the IGs for additional clarification.

5.1.3 Negative quantities or amounts are rejected.

5.1.4 Quantities and amounts have pre-adjudication edits. Refer to the appropriate segments for DMH formats.

5.1.5 Other data elements with lengths greater than SD/MC definitions are truncated.

5.1.6 Department of Mental Health is referred to as DMH in applicable receiver segments.

5.1.7 DMH processes a maximum of 50 service lines (or details) within each CLM segment. Claims with details in excess of 50 service lines per CLM segment are rejected.

5.1.8 DMH treats all 837P transactions as original claims.

5.1.9 There can be both 837I and 837P transactions in the same ISA-IEA segment.

5.1.10 The translator handles all transaction structure sorting for the submitter.

5.2. SEGMENT USAGE – 837 PROFESSIONAL

The following matrix lists only those segments required for submission with the 4010A version of the 837P HIPAA Implementation Guideline for the Department of Mental Health (DMH). Additionally, the matrix includes a column for DMH use for the transaction.

This implementation guideline identifies all required segments for 837P transactions. Failure to include a required segment results in a compliance error. A situational segment is not required for every type of transaction; however, a situational segment may be required under certain circumstances.

Segment Usage – 837 Professional

Segment ID	Loop ID	Segment Name	R – Required S - Situational
ST	N/A	Transaction Set Header	R
BHT	N/A	Beginning of Hierarchical Transaction	R
REF	N/A	Transmission Type Identifier	R
NM1	1000A	Submitter Name	R
PER	1000A	Submitter EDI Contact Information	R
NM1	1000B	Receiver Name	R
HL	2000A	Billing/Pay-To Hierarchical Level	R
PRV	2000A	Billing/Pay-to Provider Specialty Information	S
NM1	2010AA	Billing Provider Name	R
N3	2010AA	Billing Provider Address	R
N4	2010AA	Billing Provider City/State/ZIP Code	R
REF	2010AA	Billing Provider Secondary Identification	S
NM1	2010AA	Pay-To Provider Name	S
N3	2010AA	Pay-To Provider Address	S
N4	2010AA	Pay-To Provider City/State/ZIP Code	S
REF	2010AB	Pay-To Provider Secondary Identification	S
HL	2000B	Subscriber Hierarchical Level	R
SBR	2000B	Subscriber Information	R
NM1	2010BA	Subscriber Name	R
N3	2010BA	Subscriber Address	R
N4	2010BA	Subscriber City/State/ZIP Code	R
DMG	2010BA	Subscriber Demographic Information	R
NM1	2010BB	Payer Name	R
CLM	2300	Claim Information	R
DTP	2300	Date – Admission	S
DTP	2300	Date – Discharge	S
AMT	2300	Patient Amount Paid	S
REF	2300	Medical Record Number	R
HI	2300	Health Care Diagnosis	S
NM1	2310B	Rendering Provider Name	S
PRV	2310B	Rendering Provider Specialty Information	S
NM1	2310D	Service Facility Location	S
REF	2310D	Service Facility Location Secondary Identification	S
SBR	2320	Other Subscriber Information	S
CAS	2320	Claim Level Adjustments	S
AMT	2320	Coordination of Benefits (COB) Payer Paid Amount	S
AMT	2320	Coordination of Benefits (COB) Allowed Amount	S
DMG	2320	Subscriber Demographic Information	S
OI	2320	Other Insurance Coverage Information	S
NM1	2330A	Other Subscriber Name	S

Segment ID	Loop ID	Segment Name	R – Required S - Situational
NM1	2330B	Other Payer Name	S
DTP	2330B	Claim Adjudication Date	S
LX	2400	Service Line Number	R
SV1	2400	Professional Service	R
DTP	2400	Date – Service Date	R
REF	2400	Line Item Control Number	R
NM1	2420A	Rendering Provider Name	S
PRV	2420A	Rendering Provider Specialty Information	S
NM1	2420C	Service Facility Location	S
N3	2420C	Service Facility Location Address	S
N4	2420C	Service Facility Location City/State/ ZIP	S
REF	2420C	Service Facility Location Secondary ID	S
SVD	2430	Line Adjudication Information	S
CAS	2430	Line Adjustment	S
DTP	2430	Line Adjudication Date	S
SE	N/A	Transaction Set Trailer	R

5.3. SEGMENT AND DATA ELEMENT DESCRIPTION

This section contains a tabular representation of any segment required or situational for DMH HIPAA implementation of the 837P.

Segment Name		Transaction Set Header	
Segment ID		ST	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment begins the transaction.	
Example		ST*837*0001~	
Element ID	Usage	Valid Values	Comments
ST01	R	837	Transaction Set Identifier Code
ST02	R		This number is assigned by the sender ST02 must match SE02

Segment Name		Beginning of Hierarchical Transaction	
Segment ID		BHT	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment provides the bill date of the claim submitted.	
Example		BHT*0019*00*4144000001*20030416** CH~	
Element ID	Usage	Valid Values	Comments
BHT01	R	0019	Information Source
BHT02	R	00	Transaction Set Purpose Code 00 = original, 18 = reissue
BHT03	R		Originator Application Transaction Identifier
BHT04	R		Transaction Set Creation Date This date will not be used to determine the age of the claim. The date received by the state will be compared to the service dates on the service lines to determine claim age. *This date is translated to the Claim Submission Date field in the SD/MC system and therefore must be equal to or after the month and year of each date of service in the transaction or SD/MC will deny the service.*
BHT05	R		Transaction Set Creation Time
BHT06	R	CH	Claim or Encounter Identifier- "CH" only value for claiming Medi-Cal.

Segment Name		Transaction Type Identification	
Segment ID		REF	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment identifies the X12N version for test and production.	
Example		REF*87*004010x098A1~	
Element ID	Usage	Valid Values	Comments
REF01	R	87	Reference Identification Qualifier – Functional Category
REF02	R	004010x098A1	Transmission Type Code Test value should be 004010X098DA1 (Test also indicated in ISA15).

Segment Name		Submitter Name	
Segment ID		NM1	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		This will either be a county or a clearinghouse.	
Example		NM1*59*2*YORK COUNTY HEALTH CARE AGENCY*****46*59~	
Element ID	Usage	Valid Values	Comments
NM101	R	41	Entity Identifier Code
NM102	R	2	Entity Type Qualifier 1 – Person 2 –Non person
NM103	R	*Example: YORK COUNTY HEALTH CARE AGENCY*	Submitter Last Name or Organization Name assigned to TP
NM104	N/A	Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	46	Identification Code
NM109	R	*County: County Code* *Example:* 59	Submitter Identifier *County: County Code* for DMH EIN (for direct providers)

Segment Name	Submitter EDI Contact Information		
Segment ID	PER		
Loop ID	1000A		
Segment Usage	Required		
Segment Notes	Submitter EDI Contact Information		
Example	PER*IC*FERMIN*TE*1234567890*EM*abc@AAA.COM~		
Element ID	Usage	Valid Values	Comments
PER01	R	IC	IC – Information Contact
PER02	R		Submitter Contact Name Can use "Billing Department"
PER03	R	TE	Communication Number Qualifier Values Used: ED, EM, EX FX, TE Used when additional contact numbers are to be communicated Submitter's option
PER04	R		Submitters Communication Number 4155558963
PER05	S	Not Used	Communication Number Qualifier Values Used: ED, EM, EX FX, TE Used when additional contact numbers are to be communicated
PER06	S	Not Used	Communication Number
PER07	S	Not Used	Communication Number Qualifier Values Used: ED, EM, EX FX, TE Used when additional contact numbers are to be communicated
PER08	S	Not Used	Communication Number

Segment Name		Receiver Name	
Segment ID		NM1	
Loop ID		1000B	
Segment Usage		Required	
Segment Notes		Receiver of this Transaction	
Example		NM1*40*2*DMH*****46* INFOTECHWEBSVCS	
Element ID	Usage	Valid Values	Comments
NM101	R	40	Entity Identifier Code
NM102	R	2	Entity Type Qualifier 2 = Non Person Entity
NM103	R	DMH	Enter DMH
NM104	N/A	Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	46	Identification Code Qualifier
NM109	R	INFOTECHWEBSVCS	Receiver Identifier Use this value.

Segment Name		Billing/Pay-To Provider Hierarchical Level	
Segment ID		HL	
Loop ID		2000A	
Segment Usage		Required	
Segment Notes		Billing Pay-To Hierarchical Level	
Example		HL*1**20*1~	
Element ID	Usage	Valid Values	Comments
HL01	R	1	Hierarchical ID Number Must begin with 1 and increment by one each time an HL is used.
HL02	N/A	Not Used	Hierarchical Parent ID Number
HL03	R	20	Hierarchical Level Code
HL04	R	1	Hierarchical Child Code

Segment Name		Billing Pay-To Provider Specialty Information	
Segment ID		PRV	
Loop ID		2000A	
Segment Usage		Situational	
Segment Notes		Note 1 – If either the Billing or Pay-To Provider is also the Rendering Provider (i.e., Loops 2310B or 2420A will not be populated), this segment is required to pass HIPAA Validation. If you are submitting services other than Mode 12 (Outpatient Hospital), any provider taxonomy code except 282N00000X or 283Q00000X may be used. Otherwise it can be left blank. Note 2 - Do not populate taxonomy at this level if there is a mix of hospital outpatient and other outpatient on the 837. Needed to identify hospital outpatient (mode of service 12) versus other outpatient (mode of service 18). Otherwise it can be left blank.	
Example		PRV*PT*ZZ*	
Element ID	Usage	Valid Values	Comments
PRV01	R	PT	Provider Code BI = Billing, PT = Pay-To
PRV02	R	ZZ	Reference Identification Qualifier
PRV03	R		Reference Identification: 282N00000X = general hospital, 283Q00000X = psychiatric hospital. For non-24-hour services: Either value will set mode of service to 12, any other value will set mode of service to 18. See segment note for more details.

Segment Name		Billing Provider Name	
Segment ID		NM1	
Loop ID		2010AA	
Segment Usage		Required	
Segment Notes		This will either be a county or provider	
Example		NM1*85*2*YORK COUNTY HEALTH CARE AGY*****24*956000928	
Element ID	Usage	Valid Values	Comments
NM101	R	85	Entity Identifier Code
NM102	R	2	Entity Type Qualifier 1=person, 2=non person
NM103	R		Billing Provider Name. This will be passed to the 835 if Loop 2010AB is not used.
NM104	N/A	Not Used	Biller First Name
NM105	N/A	Not Used	Biller Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	24	Identification Code Qualifier; Valid Values: 24 = EIN 34 = SSN
NM109	R	123456789	Billing Provider ID EIN (or SSN) The provider's existing Short-Doyle Provider ID cannot be placed here. This will be passed to the 835 if the Pay-To Provider Loop is not sent.

Segment Name		Billing Provider Address	
Segment ID		N3	
Loop ID		2010AA	
Segment Usage		Required	
Segment Notes		Billing Provider Address	
Example		N3*66 HURLBUT STREET~	
Element ID	Usage	Valid Values	Comments
N301	R		Billing Provider Address Information
N302	S		Required if Second Address Line exists

Segment Name		Billing Provider City/State/Zip	
Segment ID		N4	
Loop ID		2010AA	
Segment Usage		Required	
Segment Notes		Billing Provider City/State/ZIP	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		City Name
N402	R		State or Province Code
N403	R		Postal Code
N404	S	Not Used	County Code

Segment Name		Billing Provider Secondary Identification	
Segment ID		REF	
Loop ID		2010AA	
Segment Usage		Situational	
Segment Notes		SD/MC Provider Number This only needs to be populated if the billing provider is the pay-to provider and is the same as the service facility location for all services on the claim. Otherwise the provider number will be extracted from Loops 2310D or 2420C as appropriate.	
Example		REF*1D*5996 ~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Qualifier 1D = Medicaid Provider Number
REF02	R	*Must be 4 characters long*	Provider Number SD/MC Provider Number This only needs to be populated if the billing provider is the same as the service facility location for all services on the claim and only one provider number applies. Otherwise the provider number will be extracted from Loops 2310D or 2420C as appropriate

Segment Name		Pay-To Provider Name	
Segment ID		NM1	
Loop ID		2010AB	
Segment Usage		SITUATIONAL	
Segment Notes		If it is used to reflect county treasurer as a separate entity, it will not be used by DMH to pay.	
Example		NM1*85*2*YORK COUNTY HEALTH CARE AGY*****24*956000928	
Element ID	Usage	Valid Values	Comments
NM101	R	87	Entity Identifier Code Not used in SD/MC
NM102	R	2	Entity Type Qualifier Not used in SD/MC
NM103	R		Pay-To Provider Name This will be passed to the 835 if sent.
NM104	N/A	Not Used	Pay-To Provider First Name Not used in SD/MC
NM105	N/A	Not Used	Pay-To Provider Middle Name Not used in SD/MC
NM106	N/A	Not Used	*
NM107	N/A	Not Used	Pay-To Provider Name Suffix Not used in SD/MC
NM108	R	24	Identification Code Qualifier
NM109	R		Pay-To Provider ID This will be passed to the 835 if sent.

Segment Name		Pay-To Provider Address	
Segment ID		N3	
Loop ID		2010AB	
Segment Usage		SITUATIONAL	
Segment Notes		Billing Provider Address	
Example		N3*66 HURLBUT STREET~	
Element ID	Usage	Valid Values	Comments
N301	R		Provider Address Information
N302	S		Required if Second Address Line exists

Segment Name		Pay-To Provider City/State/Zip	
Segment ID		N4	
Loop ID		2010AB	
Segment Usage		SITUATIONAL	
Segment Notes		Billing Provider City/State/ZIP	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		City Name
N402	R		State or Province Code
N403	R		Postal Code

Segment Name		Pay-To Provider Secondary Identification	
Segment ID		REF	
Loop ID		2010AB	
Segment Usage		Situational	
Segment Notes		This only needs to be populated if the pay-to provider is the same as the service facility location for all services on the claim. Otherwise the provider number will be extracted from Loops 2310D or 2420C as appropriate.	
Example		REF*1D*5996 ~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Qualifier
REF02	R		Provider Number (*Must be 4 characters long)* This only needs to be populated if the pay-to provider is the same as the service facility location for all services on the claim and only one provider number applies. Otherwise the provider number will be extracted from Loops 2310D or 2420C as appropriate.

Segment Name		Subscriber Hierarchical Level	
Segment ID		HL	
Loop ID		2000B	
Segment Usage		Required	
Segment Notes		Subscriber Hierarchical Level	
Example		HL*2*1*22*0~	
Element ID	Usage	Valid Values	Comments
HL01	R	2	Hierarchical ID Number Increment by 1 for each HL segment in transaction
HL02	N/A	1	Hierarchical Parent ID Number Use the HL01 value of the Billing/Pay-To Provider in 2000A
HL03	R	22	Hierarchical Level Code
HL04	R	0	Hierarchical Child Code *The subscriber is always the patient for DMH.*

Segment Name		Subscriber Information	
Segment ID		SBR	
Loop ID		2000B	
Segment Usage		Required	
Segment Notes		Subscriber Information	
Example		SBR*P*18*******MC~	
Element ID	Usage	Valid Values	Comments
SBR01	R	P	Payer Responsibility COB - Do not use "S" or "T" unless COB information is included on the claim.
SBR02	R	18	Individual Relationship Code
SBR03	N/A	Not used	Insured Group or Policy Number
SBR04	N/A	Not used	Group or Plan Name
SBR05	N/A	Not used	Insurance Type Code
SBR06	N/A	Not used	
SBR07	N/A	Not used	
SBR08	N/A	Not used	
SBR09	R	MC	Claim Filing Indicator Code

Segment Name		Subscriber Name	
Segment ID		NM1	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This segment identifies the subscriber and must include the Subscriber Identification Number.	
Example		NM1*IL*1*DOE* JOHN****MI*596009244900334~	
Element ID	Usage	Valid Values	Comments
NM101	R	IL	Entity Identifier Code IL = “Insured” or “Sebscriber”
NM102	R	1	Entity Type Qualifier For SD/MC use "1" = "person". ("2" = "non-person")
NM103	R		Subscriber Last Name or Organization
NM104	S		Subscriber First Name
NM105	N/A		Subscriber Middle Name Can be middle initial or blank
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	MI	Identification Code Qualifier MI = Member ID
NM109	R		Subscriber Identifier The same Beneficiary ID formats may be used under HIPAA as in the proprietary claim (see comments). The long-term objective format is the Client Index Number (CIN). Also, to comply with the Privacy Rule's minimum necessary disclosure of client identifiable information, it is recommended to not use the SSN. Acceptable Beneficiary Identification Formats for SD/MC: 1) County code, aid code, case, FBU, person number Example: 193R0686666011(19-3R-068666-0-11) 2) County code, aid code, "9", followed by SSN Example: 11609563600020 (11-60-9-563600020) 3) County code, aid code, "M", followed by MEDS ID or Pseudo MEDS ID Example: 1330M87940123P (13-30-M-87940123P) 4) County code, aid code, "C", followed by CIN Example: 1330C98630052A (13-30-C-98630052A) 5) SSN or MEDS-ID or CIN Example: 563600020 Example: 87940123P Example: 98630052A 6) County code,"9H", "9", followed by the CIN for Healthy Families (This format is required to submit a claim for Healthy Families Program reimbursement and indicates a mental health SED service.) Example: 599H998630052A (59-9H-9-98630052A)

Segment Name		Subscriber Address	
Segment ID		N3	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This is required due to situational guide notes, but not used in SD/MC.	
Example		N3*250 E WASHINGTON BLVD~	
Element ID	Usage	Valid Values	Comments
N301	R		Subscriber Address Line "HOMELESS" may be used if appropriate.
N302	S		Subscriber Address 2

Segment Name		Subscriber City/State/Zip	
Segment ID		N4	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This is required due to situational guide notes, but not used in SD/MC.	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		City Name *If unknown, use the provider's city.*
N402	R		State or Province Code
N403	R		Postal Code *If unknown, use the provider's postal code.*

Segment Name		Subscriber Demographic Information	
Segment ID		DMG	
Loop ID		2010BA	
Segment Usage		Required	
Segment Notes		This segment identifies the Subscriber Demographic Information.	
Example		DMG*D8*19540506*M~	
Element ID	Usage	Valid Values	Comments
DMG01	R	D8	Date expressed in format CCYYMMDD
DMG02	R	20030214	Subscriber Birth Date
DMG03	R		Subscriber Gender Identification Valid Values: M – Male F – Female U - Unknown

Segment Name		Payer Name	
Segment ID		NM1	
Loop ID		2010BB	
Segment Usage		Required	
Segment Notes		This segment identifies the payer and must include the Payer Identification Number.	
Example		NM1*PR*2*DMH*****PI*01~	
Element ID	Usage	Valid Values	Comments
NM101	R	PR	Entity Identifier Code PR = Payer
NM102	R	2	Entity Type Qualifier 2 = Non Person
NM103	R	DMH	Organization Name Use DMH
NM104	N/A	Not Used	Subscriber First Name
NM105	N/A	Not Used	Subscriber Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	PI	Identification Code Qualifier PI = Payer Identification
NM109	R	01	Payer Primary ID Use 01 - DMH, Mental Health Services

Segment Name		Claim Information	
Segment ID		CLM	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This loop should be subordinate to Loop 2000B for Short-Doyle/Medi-Cal.	
Example		CLM*1887*2361.58***55::1*Y*A*Y*Y*P*********1~	
Element ID	Usage	Valid Values	Comments
CLM01	R		Patient Account Number Patient account number or claim number is echoed back on the 835 - recommend unique numbers for each individual claim. Used to match the claim with the payment information on the 835. CLM01 on 837 ties to CLP01 on the 835.
CLM02	R		Total Claim Amount
CLM03	N/A	Not Used	Not Used
CLM04	N/A	Not Used	Not Used
CLM05	R		Place of Service Code
CLM05-01	R		Facility Type Code: Used in SD/MC if service line POS not used. Check the Service Code Crosswalk for specific codes that may be necessary depending on the services rendered. Otherwise, any valid code may be used.
CLM05-02	N/A	Not Used	Not Used
CLM05-03	R	1	All claims are processed as originals.
CLM06	R	Y	Provider Signature on File Always use "Y" unless DMH instructions indicate otherwise. Need signature on file at county for authority to bill to SD/MC
CLM07	R		Medicare Assignment Code In the absence of COB information (Loop2320), a value of "C" (Not Assigned) equals "H" (Non-Medicare certified provider) in SD/MC
CLM08	R	Y	Assignment of Benefit Indicator Always use "Y" unless DMH instructions indicate otherwise.
CLM09	R		Release of Information Code I = informed consent, Y = signature on file
CLM10	S	P	Patient Signature Source Code As recommended by federal Office of Civil Rights
CLM20	S	1	Delay Reason Code *See Crosswalk* Example : 1 *Only required if needed to provide the reason why a claim was submitted late.*

Segment Name		Date –Admission	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		DMH - Required on every 24-hour claim (Mode 05). Also required if Place of Service code (CLM05-1) equals “21.”	
Example		DTP*435*D8*20030915~	
Element ID	Usage	Valid Values	Comments
DTP01	R	435	Date/Time Qualifier
DTP02	R	D8	Date/Time Format Date expressed in format CCYYMMDD
DTP03	R		Date Time Period

Segment Name		Date –Discharge	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		DMH - 24 Hours Only (Mode 05); To be included on the last claim for the encounter. Do not submit with services that are not Mode 05.	
Example		DTP*096*D8*20030915~	
Element ID	Usage	Valid Values	Comments
DTP01	R	096	Date/Time Qualifier
DTP02	R	D8	Date/Time Format Date expressed in format CCYYMMDD
DTP03	R		Date Time Period

Segment Name		Patient Amount Paid	
Segment ID		AMT	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		This is required if the Patient has Paid any amount towards the claim	
Example		AMT*F5*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	F5	Amount Qualifier Code Medi-Cal share of cost (SOC)
AMT02	R	152.45	Patient Amount Paid; Medi-Cal share of cost (SOC). This will be placed on the 835 if provided.

Segment Name		Medical Record Number	
Segment ID		REF	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This segment Identifies the patient’s Medical Record Number.	
Example		REF*EA*7251A001~	
Element ID	Usage	Valid Values	Comments
REF01	R	EA	Reference Identification Qualifier
REF02	R		Medical Record Number Put County Patient Medical Record number here. Chart # Match to CSI Used for audits

Segment Name		Health Care Information Code	
Segment ID		HI	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		This is required on all claims with few exceptions. Do not send decimal points. The actual diagnosis pulled for a specific service will depend on the diagnosis pointer in SV107.	
Example		HI*BK:2956~	
Element ID	Usage	Valid Values	Comments
HI01-01	R	BK	Code List Qualifier Code
HI01-02	R		Industry Standard Code Value according to ICD-9 codes
HI02-01	S		Code List Qualifier Code
HI02-02	S		Industry Standard Code Value according to ICD-9 codes
HI03-01	S		Code List Qualifier Code
HI03-02	S		Industry Standard Code Value according to ICD-9 codes
HI04-01	S		Code List Qualifier Code
HI04-02	S		Industry Standard Code Value according to ICD-9 codes
HI05-01	S		Code List Qualifier Code
HI05-02	S		Industry Standard Code Value according to ICD-9 codes
HI06-01	S		Code List Qualifier Code
HI06-02	S		Industry Standard Code Value according to ICD-9 codes
HI07-01	R		Code List Qualifier Code
HI07-02	R		Industry Standard Code Value according to ICD-9 codes
HI08-01	R		Code List Qualifier Code
HI08-02	R		Industry Standard Code Value according to ICD-9 codes

Segment Name		Rendering Provider Name	
Segment ID		NM1	
Loop ID		2310B	
Segment Usage		Situational	
Segment Notes		Place the information for individual DMH former FFS counties here. If there are multiple counselors or individuals providing service, populate loop 2420A as appropriate. If taxonomy is needed that applies to the entire claim, place it here as well.	
Example		NM1*82*1*FEELGOOD*PHIL****24*9000000001~	
Element ID	Usage	Valid Values	Comments
NM101	R	82	Entity Identifier Code
NM102	R	1	Entity Type Qualifier
NM103	R		Counselor's last name
NM104	S		Counselor's first name
NM105	S	Not Used	
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	R	24	Valid Values: 24, 34, XX 24 = EIN 34 = SSN XX=National Provider ID
NM109	R	123456789	Rendering Provider ID

Segment Name		Rendering Provider Specialty Information	
Segment ID		PRV	
Loop ID		2310B	
Segment Usage		Situational	
Segment Notes		Do not populate taxonomy at this level if there is a mix of hospital outpatient and other outpatient providers on this claim. Needed to identify between hospital outpatient (mode of service 12) versus other outpatient (mode of service 18). Otherwise it can be left blank.	
Example		PRV*ZZ*103TC0700X~	
Element ID	Usage	Valid Values	Comments
PRV01	R	PE	Provider Code
PRV02	R	ZZ	Reference Identification Qualifier
PRV03	R		Reference Identification: 282N00000X = general hospital, 283Q00000X = psychiatric hospital. For non-24-hour services: Either value will set mode of service to 12, any other value will set mode of service to 18. See segment note for more details.

Segment Name		Service Facility Location	
Segment ID		NM1	
Loop ID		2310D	
Segment Usage		Situational	
Segment Notes		This should be the information for the provider site, unless the billing or pay-to provider contains the provider site information. This provider code from this loop will be used in the Short-Doyle claim system, unless the loop is not used or there are multiple provider codes for the claim. Multiple provider codes should be reflected in loop 2420C as appropriate	
Example		NM1* FA*2*A-OK MENTAL HEALTH CLINIC*****24*11122333~	
Element ID	Usage	Valid Values	Comments
NM101	R	FA	Entity Identifier Code; Other codes used 77 – Service Location FA – Facility LI – Independent Lab TL – Testing Lab
NM102	R	2	Entity Type Qualifier
NM103	S	A-OK MENTAL HEALTH CLINIC	Organization Name Required except when service was rendered in the patient's home.
NM104	N/A	Not Used	
NM105	N/A	Not Used	
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	S	24	Identification Code Qualifier
NM109	R		Identification Code

Segment Name		Service Facility Location Secondary Identification	
Segment ID		REF	
Loop ID		2310D	
Segment Usage		Required	
Segment Notes		This Segment includes the Provider Control Number.	
Example		REF*ID*9999~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Number
REF02	R	9999	Laboratory/Facility Secondary ID Place the 4 character Short-Doyle Medi-Cal Provider Number here.

Segment Name		Other Subscriber Information	
Segment ID		SBR	
Loop ID		2320	
Segment Usage		Required	
Segment Notes		Only use for COB situations, including indication of Medicare or Other Health Coverage denial.	
Example		SBR*S*18***MB****MB~	
Element ID	Usage	Valid Values	Comments
SBR01	R	P	Payer Responsibility Sequence Number Code
SBR02	R	18	Individual Responsibility Code
SBR03	N/A	Not used	
SBR04	N/A	Not used	
SBR05	R	MB	Insurance Type Code
SBR06	N/A	Not used	
SBR07	N/A	Not used	
SBR08	N/A	Not used	
SBR09	N/A	MB	Claim Filing Indicator Code See Crossover Indicator Crosswalk.

Segment Name		CLAIM LEVEL ADJUSTMENTS	
Segment ID		CAS	
Loop ID		2320	
Segment Usage		SITUATIONAL	
Segment Notes			
Example			
Element ID	Usage	Valid Values	Comments
CAS01	R		Claim Adjustment Group Code
CAS02	R		Adjustment Reason Code
CAS03	R		Claim Adjustment Reason Code
CAS04	S		Adjustment Quantity
CAS05	S		Adjustment Reason Code
CAS06	S		Adjustment Amount
CAS07	S		Adjustment Quantity
CAS08	S		Adjustment Reason Code
CAS09	S		Adjustment Amount
CAS10	S		Adjustment Quantity
CAS11	S		Adjustment Reason Code
CAS12	S		Adjustment Amount
CAS13	S		Adjustment Quantity
CAS14	S		Adjustment Reason Code
CAS15	S		Adjustment Amount
CAS16	S		Adjustment Quantity
CAS17	S		Adjustment Reason Code
CAS18	S		Adjustment Amount
CAS19	S		Adjustment Quantity

Segment Name		Coordination of Benefits (COB) Payer Paid Amount	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Required if claim has been adjudicated by the payer identified in this loop. It is acceptable to show “0” amount paid.	
Example		AMT*D*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	D	Amount Qualifier Code
AMT02	R		COB Payer Paid Amount Submitters - Crosswalk from CLP04 in 835 when doing COB. This will only be used if line level COB payment information is not available. This segment is required to pass HIPAA validation if doing COB. For non-covered services use zero (0) to satisfy the requirements.

Segment Name		COB Allowed Amount	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Only used to identify situations where a Medicare recipient is receiving services from a Medicare provider that are denied or not covered by Medicare.	
Example		AMT*B6*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	B6	Amount Qualifier Code B6 = Allowed-Actual
AMT02	R		Allowed Amount If the value is equivalent to zero, and Medicare is indicated in the COB data, this equals "N" Crossover Indicator value in SD/MC.

Segment Name		OTHER SUBSCRIBER INFORMATION	
Segment ID		DMG	
Loop ID		2320	
Segment Usage		SITUATIONAL	
Segment Notes		This segment identifies the Subscriber Demographic Information.	
Example		DMG*D8*19540506*M~	
Element ID	Usage	Valid Values	Comments
DMG01	R	D8	Date Time Period Format Qualifier
DMG02	R		Other Insured Birth Date
DMG03	R		Other Insured Gender Code Valid Values: M – Male F – Female U - Unknown
DMG04	N/A	Not Used	Marital Status Code
DMG05	N/A	Not Used	Race or Ethnicity Code
DMG06	N/A	Not Used	Citizenship Status Code
DMG07	N/A	Not Used	Country Code
DMG08	N/A	Not Used	Basis of Verification Code
DMG09	N/A	Not Used	Quantity

Segment Name		Other Insurance Coverage Information	
Segment ID		OI	
Loop ID		2320	
Usage		Situational	
Segment Notes		This information applies only to the Payer of the Claim.	
Example		OI***Y*B**Y~	
Element ID	Usage	Valid Values	Comments
OI01	N/A	Not Used	
OI02	N/A	Not Used	
OI03	R	Y	Yes/No Condition or Response Valid Values: Y – Yes N - No
OI04	R	B	Patient Signature Source Code
OI05	N/A	Not Used	
OI06	R	Y	Release of Information Code

Segment Name		Other Subscriber Name	
Segment ID		NM1	
Loop ID		2330A	
Usage		Situational	
Segment Notes		This segment identifies Other Subscriber Information in the Claim.	
Example		NM1* IL*1*DOE*JOHN****MI*19609244900334~	
Element ID	Usage	Valid Values	Comments
NM101	R	IL – Insured or Subscriber	Entity Identifier Code
NM102	R	1 – Person	Entity Type Qualifier
NM103	R	DOE	Submitter Last Name or Organization Name
NM104	N/A	JOHN Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	MI	Identification Code Qualifier
NM109	R	19609244900334	Sender Identifier

Segment Name		Other Payer Name	
Segment ID		NM1	
Loop ID		2330B	
Usage		Situational	
Segment Notes		This segment identifies Other Payer Information in the Claim.	
Example		NM1* PR*2*MEDI-CAL*****PI*951234567~	
Element ID	Usage	Valid Values	Comments
NM101	R	PR - Payer	Entity Identifier Code
NM102	R	2 – Non-Person Entity	Entity Type Qualifier
NM103	R	MEDI-CAL	Submitter Last Name or Organization Name
NM104	N/A	Not Used	Submitter First Name
NM105	N/A	Not Used	Submitter Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	PI- Payer IDENTIFICATION	Identification Code Qualifier
NM109	R	951234567	Payer Identifier

Segment Name		Date – Service Date	
Segment ID		DTP	
Loop ID		2330B	
Segment Usage		SITUATIONAL	
Segment Notes		This segment is used to specify a time period.	
Example		DTP*573*D8*20030314~	
Element ID	Usage	Valid Values	Comments
DTP01	R	573	Date/Time Qualifier
DTP02	R	D8	Date Time Period Format Qualifier.
DTP03	R		Date/Time Period

Segment Name		Service Line	
Segment ID		LX	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This segment identifies Service Lines in a Claim.	
Example		LX*1~	
Element ID	Usage	Valid Values	Comments
LX01	R	1	Line Counter Start with 1 and increment by 1 for each service line on the claim.

Segment Name		Professional Service	
Segment ID		SV1	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This segment specifies claim service detail.	
Example		SV1*HC:H0019:HE:HB*2361.58*UN*31*56**1~	
Element ID	Usage	Valid Values	Comments
SV101-01	R	HC	Product/Service ID Qualifier HC only code used. Other valid values are not used in SD/MC.
SV101-02	R		Procedure Code See Crosswalk
SV101-03	S		Procedure Modifier 1; See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV101-04	S		Procedure Modifier 2; See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV101-05	S		Procedure Modifier 3; See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV101-06	S		Procedure Modifier 4 See Crosswalk. Duplicate Payment Override may be indicated here if needed.
SV102	R		Line Item Charge Amount. Values exceeding six places to the left of the decimal cannot be processed correctly by SD/MC.
SV103	R		Unit or Basis for Measurement UN=Unit See Crosswalk
SV104	R		Service Unit Count See Crosswalk.
SV105	S		Place of Service Code Only required if the Place of Service differs from the value provided in CLM05-1. Check the Service Code Crosswalk for specific codes that may be necessary depending on the services rendered. Otherwise, any valid code may be used.
SV106	N/A	Not Used	Service Type Code Not Used
SV107-01	S		Diagnosis Code Pointer This value determines which diagnosis code provided in Loop 2300 will be used for processing. If only one diagnosis is submitted, this value should be “1”
SV108	N/A	Not Used	Monetary Amount is Not Used
SV109	S		Emergency Indicator Not used in SD/MC

Segment Name		Date – Service Date	
Segment ID		DTP	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This segment is used to specify a time period.	
Example		DTP*472*D8*20030314~	
Element ID	Usage	Valid Values	Comments
DTP01	R	472	Date/Time Qualifier
DTP02	R	D8, RD8	D8=CCYYMMDD RD8=CCYYMMDD-CCYYMMDD *RD8 should only be used for Mode 05(24-Hour Non-Hospital Services).*
DTP03	R	With D8: 20030314; with RD8: 20030314-20030322	Date/Time Period For DMH residential services when using a date range (RD8) the month and year for the "from" and "to" dates must be the same. (Claims cannot cross over months)

Segment Name		Line Item Control Number	
Segment ID		REF	
Loop ID		2400	
Segment Usage		Required	
Segment Notes		This Segment is the Provider Control Number.	
Example		REF*6R*31063~	
Element ID	Usage	Valid Values	Comments
REF01	R	6R	Reference Identification Number
REF02	R		Reference Identification Unique claim ID across all service lines. Maximum length of 23 characters due to SDMC limitations. All 30 characters will be passed through to 835. For translation to proprietary SDMC claim and EOB: A) The Claim ID Serial Number (characters 6 through 10) maps to the Line Item Control Number characters 1 through 5. B) County Use 1 maps to the Line Item Control Number characters 6 through 20. C) County Use 2 maps to the Line Item Control Number characters 21 through 23.

Segment Name		Rendering Provider Name	
Segment ID		NM1	
Loop ID		2420A	
Segment Usage		Situational	
Segment Notes		Use this loop if there are multiple counselors or other professionals rendering service. If this loop is populated for a given service the Counselor's initials will be extracted from here.	
Example		NM1* 82*1*SMITH*JUNE*L***24*87654321~	
Element ID	Usage	Valid Values	Comments
NM101	R	82	Entity Identifier Code
NM102	R	1	Entity Type Qualifier
NM103	R		Rendering Provider Last or Org Name
NM104	S		Rendering Provider First Name *Required when the provider is a person.*
NM105	S		Rendering Provider Middle Name
NM106	N/A	Not Used	Rendering Provider Name Prefix
NM107	S		Rendering Provider Name Suffix
NM108	R	24, 34	Identification Code Qualifier XX is for NPI only
NM109	R		Rendering Provider Primary ID

Segment Name		Rendering Provider Specialty Information	
Segment ID		PRV	
Loop ID		2420A	
Segment Usage		Situational	
Segment Notes		Needed to identify hospital outpatient (mode of service 12) versus other outpatient (mode of service 18) at the service level. Otherwise it can be left blank.	
Example		PRV*PT*ZZ*282N00000X~	
Element ID	Usage	Valid Values	Comments
PRV01	R	PE	Provider Code
PRV02	R	ZZ	Reference Identification Qualifier
PRV03	R		Taxonomy Code: 282N00000X = general hospital, 283Q00000X = psychiatric hospital. For non-24-hour services: Either value will set mode of service to 12, any other value will set mode of service to 18. See segment note for more details**.**

Segment Name		Service Facility Location	
Segment ID		NM1	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes		This is not used in SD/MC, but is still a required part of Loop 2420C.	
Example		NM1* TL*2*A-OK MOBILE CLINIC*****24*11122333~	
Element ID	Usage	Valid Values	Comments
NM101	R	TL	Entity Identifier Code
NM102	R	2	Entity Type Qualifier
NM103	R		Submitter Last Name or Organization Name Not used in SD/MC, but still a required part of Loop 2420C
NM104	N/A	Not used	
NM105	N/A	Not used	
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	R		Identification Code Qualifier
NM109	R		Service Facility Location ID Number

Segment Name		Service Facility Location Address	
Segment ID		N3	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes		This is not used in SD/MC, but is still a required part of Loop 2420C.	
Example		N3*66 HURLBUT STREET~	
Element ID	Usage	Valid Values	Comments
N301	R		Service Facility Location Address 1 Not used in SD/MC, but still a required part of Loop 2420C
N302	S		Service Facility Location Address 2

Segment Name		Service Facility Location City/State/ ZIP	
Segment ID		N4	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes		This is not used in SD/MC, but is still a required part of Loop 2420C.	
Example		N4*PASADENA*CA*91104~	
Element ID	Usage	Valid Values	Comments
N401	R		Service Facility Location City Not used in SD/MC, but still a required part of Loop 2420C
N402	R		Service Facility Location State Not used in SD/MC, but still a required part of Loop 2420C
N403	R		Service Facility Location ZIP Not used in SD/MC, but still a required part of Loop 2420C

Segment Name		Service Facility Location Secondary ID	
Segment ID		REF	
Loop ID		2420C	
Segment Usage		Situational	
Segment Notes			
Example		REF*1D*8096 ~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	Reference Identification Qualifier
REF02	R		Service Facility Location Secondary ID SD/MC Provider Code *Must be 4 characters long*

Segment Name		Line Adjudication Information	
Segment ID		SVD	
Loop ID		2430	
Segment Usage		Situational	
Segment Notes		Used for Medicare and other Health Coverage amount.	
Example		SVD*43*55*HC: 90829**3~	
Element ID	Usage	Valid Values	Comments
SVD01	R	43	Other Payer Primary ID
SVD02	R	55	Service Line Paid Amount This is the primary value that will be used if available.
SVD03	R		Procedure Identifier
SVD03-01	R	HC	Product or Service ID Qualifier
SVD03-02	R	90829	Procedure Code
SVD03-03	S		Procedure Modifier 1
SVD03-04	S		Procedure Modifier 2
SVD03-05	S		Procedure Modifier 3
SVD03-05	S		Procedure Modifier 4
SVD03-06	S		Procedure Code Description
SVD04	N/A	NOT USED	
SVD05	S		Paid Units of Service
SVD05	S		Bundled Line Number

Segment Name		LINE ADJUSTMENT	
Segment ID		CAS	
Loop ID		2430	
Segment Usage		SITUATIONAL	
Segment Notes			
Example			
Element ID	Usage	Valid Values	Comments
CAS01	R		Adjustment Reason Code - Line Level
CAS02	R		Adjustment Reason Code
CAS03	R		Claim Adjustment Reason Code
CAS04	S		Adjustment Quantity
CAS05	S		Adjustment Reason Code
CAS06	S		Adjustment Amount
CAS07	S		Adjustment Quantity
CAS08	S		Adjustment Reason Code
CAS09	S		Adjustment Amount
CAS10	S		Adjustment Quantity
CAS11	S		Adjustment Reason Code
CAS12	S		Adjustment Amount
CAS13	S		Adjustment Quantity
CAS14	S		Adjustment Reason Code
CAS15	S		Adjustment Amount
CAS16	S		Adjustment Quantity
CAS17	S		Adjustment Reason Code
CAS18	S		Adjustment Amount
CAS19	S		Adjustment Quantity

Segment Name		Line Adjudication Date	
Segment ID		DTP	
Loop ID		2430	
Segment Usage		Situational	
Segment Notes			
Example		DTP*573*D8*20030314~	
Element ID	Usage	Valid Values	Comments
DTP01	R	573	Date Time Qualifier
DTP02	R		Date Time Period Format Qualifier
DTP03	R		Adjudication or Payment Date

Segment Name		Transaction Set Trailer	
Segment ID		SE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		Transaction Set Trailer Counts	
Example		SE*34*0001~	
Element ID	Usage	Valid Values	Comments
SE01	R		Number of Included Segments
SE02	R		Transaction Set Control Number Must match ST02 of this transaction

5.4. EXAMPLE OF AN 837P TRANSACTION

	Interchange Control Header (L_ISA)
1	ISA*00* *00* *ZZ*C5900000000000*ZZ*INFOTECHWEBSVCS *030918*1659*U*00401*000000864*0*P*:~
	Functional Group Header (L_GS)
2	GS*HC*C5900000000000*INFOTECHWEBSVCS *20030918*105531*1*X*004010X098A1~
	Transaction Set Header (837P)
3	ST*837*0001~
4	BHT*0019*00*4144000001*20030826**CH~
5	REF*87*004010X098A1~
	Submitter Name (1000A)
6	NM1*41*2*York County Health Care Agency*****46*59~
7	PER*IC*Billing Contact Person*TE*2135953450~
	Receiver Name (1000B)
8	NM1*40*2*DMH*****46*INFOTECHWEBSVCS~
	Billing/Pay-to Provider Hierarchical Level (2000A)
9	HL*1**20*1~
10	PRV*PT*ZZ*282N00000X~
	Billing Provider Name (2010AA)
11	NM1*85*2*Interconnection Center, Inc.*****24*12-1234567~
12	N3*3833 South Grand Avenue~
13	N4*Los Angeles*CA*90037~ REF*1D*9991
	Subscriber Hierarchical Level (2000B)
14	HL*2*1*22*0~
15	SBR*P*18*******MC~
	Subscriber Name (2010BA)
16	NM1*IL*1*Bond*James*K***MI*596009244900334~
17	N3*123 Bond Ave~
18	N4*Bondland*CA*95630~
19	DMG*D8*19481223*M~
	Payer Name (2010BB)
20	NM1*PR*2*DMH*****PI*01~
	Claim Information (2300)
21	CLM*A123B456***300***22::1*Y*C*Y*Y*P~
22	DTP*435*D8*20030501~
23	REF*EA*A1234B5678~
24	HI*BK:2956~
	Service Facility Location (2310D)
25	NM1*FA*2*Interconnection Center, Inc.*24*11122333~
26	N3*3833 South Grand Avenue~
27	N4*Los Angeles*CA*90037~
28	REF*1D*9999~
	Service Line (2400)
29	LX*1~
30	SV1*HC:S9484:HE:TG***100***UN*1*20**1~
31	DTP*472*D8*20030501~

32 REF*6R*31063~

Service Line (2400)

33 LX*2~
34 SV1*HC:S9484:HE:TG***100***UN*1*23**1~
35 DTP*472*D8*20030502~
36 REF*6R*31064~

Service Line (2400)

37 LX*3~
38 SV1*HC:H2012:HE***100***UN*4***1~
39 DTP*472*D8*20030503~
40 REF*6R*31065~

Claim Information (2300)

41 CLM*A123B457*123.12***22::1*Y*C*Y*Y*P~
42 DTP*435*D8*20030501~
43 REF*EA*A12345678~
44 HI*BK:2899~

Service Facility Location (2310D)

45 NM1*FA*2*Interconnection Center, Inc.~
46 N3*3833 South Grand Avenue~
47 N4*Los Angeles*CA*90037~
48 REF*1D*7019~

Service Line (2400)

49 LX*1~
50 SV1*HC:S9484:HE:TG***100***UN*1*20**1~
51 DTP*472*D8*20030501~
52 REF*6R*31063~

Service Line (2400)

53 LX*2~
54 SV1*HC:T1017:HE*23.12*UN*.87***1~
55 DTP*472*D8*20030502~
56 REF*6R*31064~

Transaction Set Trailer (837P)

57 SE*60*0001~

Functional Group Trailer (L_GS)

58 GE*1*1~

Interchange Control Trailer (L_ISA)

59 IEA*1*000000864~

6. 837 INSTITUTIONAL CLAIMS AND ENCOUNTERS

6.1. DESCRIPTION OF THE LAYOUT OF THE DATA

The ASC X12N 837 (04010X096A1) transaction is the HIPAA mandated instrument by which institutional claims or encounter data must be submitted. As per HIPAA regulation, all electronic institutional claims should be submitted using this transaction. However, for counties not yet compliant with HIPAA, DMH will continue to accept claims in proprietary format.

This document is intended only as a companion guide and is not intended to contradict or replace any information in the IGs or DMH regulations, Letters, and Notices. It is highly recommended that implementers have the following resources available during the development process:

- This document, Companion Guide
- ASC X12N 837 (004010X096) and the 004010X096A1 Addenda

Additionally, there are several processing assumptions, limitations, and guidelines that a developer must be aware of when implementing the 837I transaction. The following list identifies these processing stipulations:

6.1.1 DMH has lifted restrictions accepting more than 5000 CLM segments per ST – SE. The IGs recommended creating this limitation to avert circumstances where file size management may become an issue. DMH will instead monitor the processing times for larger claim files to ensure maximum translator performance.

6.1.2 Only one SV2 segment will be accepted per CLM segment. This is necessary to support a unique SD/MC Claim ID for each service line on an 837I.

6.1.3 All monetary amounts have explicit decimals. The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer, decimal point at the right end, the decimal point should be omitted. See the IGs for additional clarification.

6.1.4 Negative quantities or amounts are rejected.

6.1.5 Quantities and amounts have pre-adjudication edits. Refer to the appropriate segments for DMH formats.

6.1.6 Other data elements with lengths greater than DMH definitions are truncated.

6.1.7 Department of Mental Health is referred to as DMH in applicable receiver segments.

6.1.8 DMH treats all 837I transactions as original claims.

6.1.9 There can be 837I and 837P transactions in the same ISA-IEA segment.

6.1.10 The translator handles all transaction structure sorting for the submitter.

6.2. SEGMENT USAGE – 837 INSTITUTIONAL

The following matrix lists only those segments required for submission with the 4010 version of the 837I HIPAA Implementation Guideline for the Department of Mental Health (DMH). Additionally, the matrix includes a column for DMH use for the transaction.

This implementation guideline identifies all required segments for 837I transactions. Failure to include a required segment results in a compliance error. A situational segment is not required for every type of transaction; however, a situational segment may be required under certain circumstances.

Segment Usage – 837 Institutional

Segment	Loop ID	Segment Name	R – Required	Description

ID			S - Situational	
ST	N/A	Transaction Set Header	R	See 837P
BHT	N/A	Beginning of Hierarchical Transaction	R	See 837P
REF	N/A	Transmission Type Identifier	R	
NM1	1000A	Submitter Name	R	See 837P
PER	1000A	Submitter EDI Contact Information	R	See 837P
NM1	1000B	Receiver Name	R	See 837P
HL	2000A	Billing/Pay-To Hierarchical Level	R	See 837P
PRV	2000A	Billing/Pay-to Provider Specialty Information	S	See 837P
NM1	2010AA	Billing Provider Name	R	See 837P
N3	2010AA	Billing Provider Address	R	See 837P
N4	2010AA	Billing Provider City/State/ZIP Code	R	See 837P
REF	2010AA	Billing Provider Secondary Information	R	See 837P
NM1	2010AB	Pay-To Provider Name	S	See 837P
N3	2010AB	Pay-To Provider Address	S	See 837P
N4	2010AB	Pay-To Provider City/State/ZIP Code	S	See 837P
REF	2010AB	Pay-To Provider Secondary Information	S	See 837P
HL	2000B	Subscriber Hierarchical Level	R	See 837P
SBR	2000B	Subscriber Information	R`	See 837P
NM1	2010BA	Subscriber Name	R	See 837P
N3	2010BA	Subscriber Address	R	See 837P
N4	2010BA	Subscriber City/State/ZIP Code	R	See 837P
DMG	2010BA	Subscriber Demographic Information	R	See 837P
NM1	2010BC	Payer Name	R	See 837P Loop 2010BB
CLM	2300	Claim Information	R	
DTP	2300	Discharge Hour	S	
DTP	2300	Statement Date	R	
DTP	2300	Admission Date/Hour	S	
CL1	2300	Institutional Claim Code	S	
AMT	2300	Patient Amount Paid	S	See 837P
REF	2300	Medical Record Number	S	See 837P
HI	2300	Principal, Admitting, E-Code-and Patient Reason for Visit Diagnosis Information	R	
NM1	2310A	Attending Physician Name	R	
NM1	2310E	Service Facility Location	S	See 837P
REF	2310E	Service Facility Location Secondary Identification	S	See 837P
SBR	2320	Other Subscriber Information	S	
CAS	2320	Claim Adjustments		
AMT	2320	Payer Prior Payment	S	
AMT	2320	Coordination of Benefits (COB) Allowed Amount	S	See 837P
DMG	2320	Subscriber Demographic Information	S	See 837P
OI	2320	Other Insurance Coverage Information	S	See 837P
NM1	2330A	Other Subscriber Name	S	See 837P
NM1	2330B	Other Payer Name	S	See 837P
DTP	2330B	Claim Adjudication Date	S	See 837P
LX	2400	Service Line Number	R	See 837P
SV2	2400	Institutional Service Line	R	
SVD	2430	Line Adjudication Information	S	See 837P
CAS	2430	Line Adjustment	S	See 837P
DTP	2430	Line Adjudication Date	S	See 837P
SE	N/A	Transaction Set Trailer	R	See 837P

6.3. SEGMENT AND DATA ELEMENT DESCRIPTION

This section contains a tabular representation of any segment required or situational for the State of California HIPAA implementation of the 837I. Each segment table contains rows and columns describing different segment elements. Those components are as follows:

- Segment Name –industry assigned segment name as identified in the IGs
- Segment ID –industry assigned segment ID as identified in the IGs
- Loop ID –loop within which the segment should appear
- Segment Usage – identifies the segment as required or situational
- Segment Notes –brief description of the purpose or use of the segment
- Example –example of a complete segment
- Element ID –industry assigned data element ID as identified in the IGs
- Usage – identifies the data element as R-required, S-situational, or N/A-not used based on DMH guidelines
- Guide Description/Valid Values – Industry name associated with the data element. If no industry name exists, this is the IGs data element name. This column also lists in BOLD the values and/or code sets to be used.
- Comments – Description of the contents of the data elements including field lengths.
- Segments common to the 837P and 837I transactions are described in the 837P section.

Segment Name		Transaction Type Identification	
Segment ID		REF	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment identifies the X12N version for test and production.	
Example		REF*87*004010X096A1~	
Element ID	Usage	Valid Values	Comments
REF01	R	87	Reference Identification Qualifier – Functional Category
REF02	R	004010x096A1	Transmission Type Code Test value should be 004010X098DA1 (Test also indicated in ISA15).

Segment Name		Claim Information	
Segment ID		CLM	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This loop should be subordinate to Loop 2000B for Short-Doyle/Medi-Cal. Unique claim ID per service line, requiring one service line loop per claim information loop. Maximum length of 23 characters due to SDMC limitations. All 38 characters will be passed through to 835 CLP01. For translation to proprietary SDMC claim and EOB: A) The Claim ID Serial Number (characters 6 through 10) maps to the Patient Account Number characters 1 through 5. B) County Use 1 maps to the Patient Account Number characters 6 through 20. C) County Use 2 maps to the Patient Account Number characters 21 through 23.	
Example		CLM*90001*826.78***11:A:1*Y*A*Y*Y*********N~	
Element ID	Usage	Valid Values	Comments
CLM01	R		Patient Account Number
CLM02	R		Total Claim Amount
CLM03	N/A	Not Used	
CLM04	N/A	Not Used	
CLM05	R	Not Used	Place of Service Code
CLM05-1	R	11	Facility Type Code: Refer to Code Source 237 for list of HIPAA Accepted Values. 11 = Inpatient hospital; maintained by NUBC.
CLM05-2	N/A	Not Used	
CLM05-3	R	1	1=Admit & Discharge Claim 2=Interim 1st Claim 3=Interim Continuing Claim 4=Interim Last Claim 5=Late Charges
CLM06	R	Y	Provider Signature on File Always use “Y” unless DMH instructions indicate otherwise. Need signature on file at county or (direct provider) for authority to bill SDMC.
CLM07	R	A, C	Medicare Assignment Code A = Assigned. A value of “C” (not assigned) equals “H” (non-medicare certified provider) in SDMC.
CLM08	R	Y or N	Assignment of Benefit Indicator Always use “Y” unless DMH instructions indicate otherwise.
CLM09	R	Y	Release of Information Code
CLM18	R	Y, N	Explanation of Benefits Indicator Y = paper EOB, N = no paper EOB.

Segment Name		DISCHARGE HOUR	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Situational	
Segment Notes		Hospital Inpatient. To be included on the last claim for the encounter. This segment is required on all final inpatient claims.	
Example		DTP*096* TM *2100~	
Element ID	Usage	Valid Values	Comments
DTP01	R	096	Date/Time Qualifier
DTP02	R	TM	Date/Time Format
DTP03	R		Date Time Period

Segment Name		STATEMENT DATES	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		REQUIRED	
Segment Notes		Hospital Inpatient claims (mode of service 07, 08, & 09).	
Example		DTP*434* RD8*20031202-20031204~	
Element ID	Usage	Valid Values	Comments
DTP01	R	434	Date/Time Qualifier
DTP02	R	RD8	Date/Time Format D8 = CCYYMMDD, RD8=CCYYMMDD-CCYYMMDD
DTP03	R		Statement from or to Date When using a date range (RD8) the month and year for the “from” and “to” dates must be the same.

Segment Name		ADMISSION DATE/HOUR	
Segment ID		DTP	
Loop ID		2300	
Segment Usage		Required on Inpatient Claims	
Segment Notes		Hospital Inpatient claims (mode of service 07, 08, & 09).	
Example		DTP*435*DT*200309152100~	
Element ID	Usage	Valid Values	Comments
DTP01	R	435	Date/Time Qualifier
DTP02	R	DT	Date/Time Format
DTP03	R		Date Time Period

Segment Name		INSTITUTIONAL CLAIM CODE	
Segment ID		CL1	
Loop ID		2300	
Segment Usage		Required on Inpatient Claims	
Segment Notes		This segment is used for each Hospital Inpatient claim, Mode of Service = 07, 08, & 09	
Example		CL1*3*1*30~	
Element ID	Usage	Valid Values	Comments
CL101	R	1, 2, 3	Admission Type Code 1 = emergency; 2 = urgent, 3 = elective May be used for ID of emergency service only patients after Phase I.
CL102	R	1	Admission Source Code 1 = Physician Referral
CL103	R	01	Patient Status Code 01 = Discharged to home or self-care.

Segment Name		Health Care Information Code	
Segment ID		HI	
Loop ID		2300	
Segment Usage		Required	
Segment Notes		This is required on all claims with few exceptions. Do not send decimal points. The actual diagnosis pulled for a specific service will depend on the diagnosis pointer in SV107.	
Example		HI*BK:2956~	
Element ID	Usage	Valid Values	Comments
HI01-01	R	BK	Code List Qualifier Code
HI01-02	R		Industry Standard Code Value according to ICD-9 codes
HI02-01	S		Code List Qualifier Code
HI02-02	S		Industry Standard Code Value according to ICD-9 codes
HI03-01	S		Code List Qualifier Code
HI03-02	S		Industry Standard Code Value according to ICD-9 codes
HI04-01	S		Code List Qualifier Code
HI04-02	S		Industry Standard Code Value according to ICD-9 codes
HI05-01	S		Code List Qualifier Code
HI05-02	S		Industry Standard Code Value according to ICD-9 codes
HI06-01	S		Code List Qualifier Code
HI06-02	S		Industry Standard Code Value according to ICD-9 codes
HI07-01	R		Code List Qualifier Code
HI07-02	R		Industry Standard Code Value according to ICD-9 codes
HI08-01	R		Code List Qualifier Code
HI08-02	R		Industry Standard Code Value according to ICD-9 codes

Segment Name		ATTENDING PHYSICIAN NAME	
Segment ID		NM1	
Loop ID		2310A	
Segment Usage		Required on Inpatient Claims	
Segment Notes		Required on all inpatient claims. Applies to the entire claim unless it is overridden on a service line by the presence of Loop ID 2410 with the same value in NM101. Name of the attending physician	
Example		NM1*71*1*JONES*JOHN*J***24*999370000~	
Element ID	Usage	Valid Values	Comments
NM101	R	71	Entity Identifier Code
NM102	R	1,2	Entity Type Qualifier (1=Person, 2=Non Person)
NM103	R		Attending Physician Last name
NM104	S		Attending Physician First name
NM105	S	Not Used	Attending Physician Middle Name
NM106	N/A	Not Used	
NM107	N/A	Not Used	
NM108	R	24	Identification Code Qualifier Valid Values: 24, 34, XX
NM109	R	123456789	Attending Provider Primary Identifier

Segment Name		Other Subscriber Information	
Segment ID		SBR	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Only use for COB situations, including indication of Medicare or Other Health Coverage denial.	
Example		SBR*S*18*351630*Medicare*****MB~	
Element ID	Usage	Valid Values	Comments
SBR01	R	S	Payer Responsibility Sequence Number Code
SBR02	R	18	Individual Responsibility Code
SBR03	S		Insured Group or Policy Number
SBR04	S		Other Insured Group Name
SBR05	N/A	Not used	
SBR06	N/A	Not used	
SBR07	N/A	Not used	
SBR08	N/A	Not used	
SBR09	S	MA	Claim Filing Indicator Code **See Crossover Indicator Crosswalk.**

Segment Name		CLAIM LEVEL ADJUSTMENTS	
Segment ID		CAS	
Loop ID		2320	
Segment Usage		SITUATIONAL	
Segment Notes			
Example			
Element ID	Usage	Valid Values	Comments
CAS01	R	PR	Claim Adjustment Group Code
CAS02	R		Adjustment Reason Code
CAS03	S		Claim Adjustment Reason Code
CAS04	S		Adjustment Quantity
CAS05	S		Adjustment Reason Code
CAS06	S		Adjustment Amount
CAS07	S		Adjustment Quantity
CAS08	S		Adjustment Reason Code
CAS09	S		Adjustment Amount
CAS10	S		Adjustment Quantity
CAS11	S		Adjustment Reason Code
CAS12	S		Adjustment Amount
CAS13	S		Adjustment Quantity
CAS14	S		Adjustment Reason Code
CAS15	S		Adjustment Amount
CAS16	S		Adjustment Quantity
CAS17	S		Adjustment Reason Code
CAS18	S		Adjustment Amount
CAS19	S		Adjustment Quantity

Segment Name		PAYER PRIOR PAYMENT	
Segment ID		AMT	
Loop ID		2320	
Segment Usage		Situational	
Segment Notes		Required if claim has been adjudicated by the payer identified in this loop. It is acceptable to show “0” amount paid.	
Example		AMT*C4*152.45~	
Element ID	Usage	Valid Values	Comments
AMT01	R	C4	Amount Qualifier Code
AMT02	R		Other Payer Patient Paid Amount Submitters - Crosswalk from CLP04 in 835 when doing COB. This will only be used if line level COB payment information is not available.

Segment Name		Institutional Service Line	
Segment ID		SV2	
Loop ID		2400	
Usage		Required	
Segment Notes		This segment specifies claim service detail.	
Example		SV2*0100*HC:H2015:HE*838.2*DA*1*838.2~	
Element ID	Usage	Valid Values	Comments
SV201	R		Service Line Revenue Code See Crosswalk
SV202-01	R	HC	Product or Service ID Qualifier
SV202-02	R		HCPCS Procedure Code See Crosswalk
SV202-03	S		HCPCS Modifier 1 See Crosswalk
SV202-04	S		HCPCS Modifier 2 See Crosswalk
SV202-05	S		HCPCS Modifier 3 See Crosswalk
SV202-06	S		HCPCS Modifier 4 See Crosswalk
SV202-07	S	Not Used	
SV203	R		Line Item Charge Amount
SV204	R		Unit or Basis for Measurement Code
SV205	R		Service Line Units
SV206	S		Service Line Rate Amount Required when revenue code (SV201) is 100-219. (should be a daily rate)
SV207	S		Service Line Non-Covered Charge Amount

6.4. EXAMPLE OF A 837I TRANSACTION

Interchange Control Header (L_ISA)

1 ISA*00* *00* *ZZ*C59000000000000*ZZ*INFOTECHWEBSVCS*930918*11659*U*00401*000000905*1*T*:~

Functional Group Header (L_GS)

2 GS*HC*C59*INFOTECHWEBSVCS*20030918*1055*1*X*004010X096A1~

Transaction Set Header (837I)

3 ST*837*10001~

4 BHT*0019*00*4144000001*20030918**CH~

5 REF*87*004010X096A1~

Receiver Name (1000B)

6 NM1*40*2*DMH*****46*INFOTECHWEBSVCS~

Submitter Name (1000A)

7 NM1*41*2*YORK COUNTY HEALTH CARE AGENCY*****46*12345~

8 PER*IC*JANE DOE*TE*9005555555~

Billing/Pay-To Provider Hierarchical Level (2000A)

9 HL*1**20*1~

10 PRV*PT*ZZ*207K00000X~

Billing Provider Name (2010AA)

11 NM1*85*2*YORK COUNTY HEALTH CARE AGENCY*****24*330127000~

12 N3*225 MAIN STREET BARKLEY BUILDING~

13 N4*CENTERVILLE*PA*17111~

14 REF*1D*5901~

Subscriber Hierarchical Level (2000B)

15 HL*2*1*22*0~

16 SBR*P*18*******MC~

Subscriber Name (2010BA)

17 NM1*IL*1*DOE*JOHN*T***MI*91234567C~

18 N3*125 CITY AVENUE~

19 N4*CENTERVILLE*PA*17111~

20 DMG*D8*19261111*M~

Payer Name (2010BC)

21 NM1*PR*2*DMH*****PI*01~

Claim information (2300)

22 CLM*90001*1600***11:A:1*Y*A*Y*Y*********N~

23 DTP*435*D8*200309112100~

24 DTP*434*RD8*20030911-20030913
DTP*096*TM*1130

25 CL1*1*1*01~

26 HI*BK:2956~

Attending Physician Name (2310A)

27 NM1*71*1*JONES*JOHN*J***24*999370000~

Other Subscriber Information (2320)

28 SBR*P*18*351630*MEDICARE*****MB~

Service Line Number (2400)

29 LX*1~

30 SV2*0100*HC:H2015:HE*1600*DA*2*800~

Subscriber Hierarchical Level (2000B)

31 HL*3*1*22*0~
32 SBR*P*18*******MC~

Subscriber Name (2010BA)

33 NM1*IL*1*DOE*JOHN*T***MI*91234567C~
34 N3*125 CITY AVENUE~
35 N4*CENTERVILLE*PA*17111~
36 DMG*D8*19261111*M~

Payer Name (2010BC)

37 NM1*PR*2*DMH*****PI*01~

Claim information (2300)

38 CLM*90002*800***11:A:1*Y*A*Y*Y*********N~
39 DTP*435*D8*200309020200~
40 DTP*434*D8*20030902~
DTP*096*TM*1400
41 CL1*1*1*01~
42 HI*BK:2956~

Attending Physician Name (2310A)

43 NM1*71*1*JONES*JOHN*J***24*999370000~

Other Subscriber Information (2320)

44 SBR*S*01*351630*MEDICARE*****MB~

Other Subscriber Name (2330A)

45 NM1*IL*1*DOE*JANE*S***MI*222004433~
46 N3*125 CITY AVENUE~
47 N4*CENTERVILLE*PA*17111~

Other Payer Name (2330B)

48 NM1*PR*2*STATE TEACHERS*****PI*1135~

Service Line Number (2400)

49 LX*1~
50 SV2*0100*HC:H2015:HE*800*DA*1*800~

Transaction Set Trailer (837I)

51 SE*61*10001~

Functional Group Trailer (L_GS)

52 GE*1*1~

Interchange Control Trailer (L_ISA)

53 IEA*1*000000905~

7. 835 CONTROL SEGMENTS/ENVELOPE STRUCTURE

7.1. OVERVIEW

The 835 transaction is the Health Care Claim Payment/Advice or an electronic Remittance Advise and/or payment. Appendix A, Section A.1.1 of each X12N HIPAA IGs provides details about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an electronic envelope. The communication envelope consists of an interchange envelope and functional groups. The interchange control structure is used for inbound and outbound files. An inbound interchange control structure is the envelope that wraps all transaction data (ST-SE) sent to DMH for processing, examples include 837 and 997 transactions. An outbound interchange control structure wraps transactions that are created by DMH and returned to the requesting provider. Examples of outbound transactions include 835 and 997 transactions. The following tables define the use of this control structure as it relates to communication with DMH.

7.2. SEGMENT AND DATA ELEMENT DESCRIPTION

Each segment table contains rows and columns describing different segment elements. Those components are as follows:

- Segment Name – The industry assigned segment name as identified in the IGs
- Segment ID – The industry assigned segment ID as identified in the IGs
- Loop ID – The loop within which the segment should appear
- Segment Usage – Identifies the segment as required or situational
- Segment Notes – A brief description of the purpose or use of the segment
- Example – An example of a complete segment
- Element ID – The industry assigned data element ID as identified in the IGs
- Usage – Identifies the data element as R-required, S-situational, or N/A-not used based on DMH guidelines
- Valid values – If any value exists then that value only is expected. If this is blank then it is TP discretion to use appropriate value.
- Guide Description/Valid Values – Industry name associated with the data element. If no industry name exists, this is the IGs data element name. This column also lists in BOLD the values and/or code sets to be used.
- Comments – Description of the contents of the data elements including field lengths.

7.3. ISA-IEA SEGMENTS

This section describes DMH's use of the interchange control segments. It includes a description of expected sender and receiver codes and delimiters.

Segment Name		Interchange Control Header	
Segment ID		ISA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		All positions within each data element in the ISA segment must be filled. Delimiters are specified in the Interchange Header Segment. The values are as follows: * Asterik Data Element Separator : Colon Sub element Separator ~ Tilde Segment Terminator	
Example		ISA*00* *00* *ZZ*INFOTECHWEBSVCS*ZZ*C59000000000000*030930*1256*U*00401*000000636*0*P*:~	
Element id	Usage	Valid values	Comments
ISA01	R	00	Authorization Information Qualifier
ISA02	R	*10 Blanks*	Authorization Information; Fixed Length
ISA03	R	00	Security Information Qualifier
ISA04	R	*10 Blanks*	Security Information:
ISA05	R	ZZ	Interchange ID Qualifier
ISA06	R	INFOTECHWEBSVCS	
ISA07	R	ZZ	Interchange ID Qualifier;
ISA08	R		For County: C + County Code + 12 Zeroes, Examples: C59000000000000
ISA09	R		Interchange Date; the date format is YYMMDD The date on which 835 is created
ISA10	R		Interchange Time; the time format is HHMM The time at which 835 is created
ISA11	R	U	Interchange Control Standards Identifier
ISA12	R	00401	Interchange Control Version Number
ISA13	R		Running serial number for each trading partner
ISA14	R	0	Acknowledgment Requested; If value were 1 = Interchange Acknowledgment (TAI01); Not currently supported 0 – No Interchange Acknowledgment Requested
ISA15	R		Usage Indicator: T for Test P for Production
ISA16	R	:	Component Element Separator: The component element separator is a delimiter and not a data element. It is used with composite data elements such as CLM05.

Segment Name		Interchange Control Trailer	
Segment ID		IEA	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		IEA*1*000000636~	
Element ID	Usage	Valid Values	Comments
IEA01	R	1	Number of included functional groups; Number of functional groups included in this interchange envelope
IEA02	R		Authorization Information same as ISA13

7.4. GS-GE SEGMENTS

This section describes the DMH use of the functional group control segments and the expected sender and receiver codes as defined in the Trading Partner Agreement. There can be multiple GS-GE segments in one ISA-IEA segment.

Segment Name		Functional Group Header	
Segment ID		GS	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		Indicates the beginning of a functional group and to provide control information.	
Example		GS*HP*INFOTECHWEBSVCS*C59000000000000*20030930*1256*614*X*004010X091A1~	
Element ID	Usage	Valid Values	Comments
GS01	R	HP	Functional Identifier Code
GS02	R	INFOTECHWEBSVCS	
GS03	R	*For County: C + County Code + 12 Zeroes, Examples:* C59000000000000	Application Receivers Code
GS04	R		Date - CCYYMMDD
GS05	R		Time - HHMMSS
GS06	R		Group Control Number
GS07	R	X	Responsible Agency Code
GS08	R	004010X091A1	Version identifier code

Segment Name		Functional Group Trailer	
Segment ID		GE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		None	
Example		GE*5*614~	
Element ID	**Usage**	**Valid Values**	**Comments**
GE01	R		Number of Transaction Sets Included
GE02	R		Group Control Number same as GS06

7.5. SAMPLE INTERCHANGE CONTROL

```
ISA*00*          *00*          *ZZ*INFOTECHWEBSVCS*ZZ*C59000000000000*030930*1256*U*
00401*000000636*0*P*:~
GS*HP*INFOTECHWEBSVCS*C59000000000000*20030930*1256*614*X*004010X091A1~
ST – 835 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 835 TRANSACTION SET TRAILER
ST – 835 TRANSACTION SET HEADER
DETAIL SEGMENTS
SE – 835 TRANSACTION SET TRAILER
GE*5*614~
IEA*1*000000636~
```

8. PROFESSIONAL AND INSTITUTIONAL CLAIMS AND ENCOUNTERS

8.1. SEGMENT USAGE – 835

The following matrix lists only those segments used by DMH in creating the 835, using the 4010A1 version of the 835 HIPAA Implementation Guideline

This implementation guideline identifies all required segments for 835 Transactions. A situational segment is not required for every type of transaction; however, a situational segment may be required under certain circumstances.

Segment Usage – 835

Segment ID	Loop ID	Segment Name	R – Required S - Situational
ST	N/A	Transaction Set Header	R
BPR	N/A	Financial Information	R
TRN	N/A	Reassociation Trace Number	R
REF	N/A	Receiver Identification	R
DTM	N/A	Production Date	R
N1	1000A	Payer Identification	R
N3	1000A	Payer Address	R
N4	1000A	Payer City, State, Zip Code	R
N1	1000B	Payee Identification	R
LX	2000	Header Number	R
CLP	2100	Claim Level Data	R
NM1	2100	Patient Name	R
NM1	2100	Corrected Patient Insured Name	R
NM1	2100	Service Provider Name	R
NM1	2100	Corrected Priority Provider Name	R
REF	2100	Other Claim Related Information	R
REF	2100	Other Claim Related Information	R
REF	2100	Other Claim Related Information	R
DTM	2100	Claim Date	R
AMT	2100	Claim Supplemental Information	S
SVC	2110	Service Payment Information	R
DTM	2110	Service Date	R
CAS	2110	Service Adjustment	S
REF	2110	Service Identification	R
REF	2110	Rendering Provider Information	S
AMT	2110	Service Supplemental Quantity	S
LQ	2110	Health Care Remark Codes	S
PLB	N/A	Provider Adjustment	S
SE	N/A	Transaction Set Trailer	R

8.2. SEGMENT AND DATA ELEMENT DESCRIPTION

This section contains a tabular representation of any segment required or situational for the State of California HIPAA implementation of the 835.

Segment Name		Transaction Set Header	
Segment ID		ST	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment begins the transaction.	
Example		ST*835*0001~	
Element ID	Usage	Valid Values	Comments
ST01	R	835	Transaction Set Identifier Code
ST02	R	0001	Transaction Set Control Number

Segment Name		Financial Information	
Segment ID		BPR	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment is used to address a single payment to a single payee; The usage of this segment by DMH is only as a Notification. No Remittance information is included.	
Example		BPR*H*0*C*NON**********20031001~	
Element ID	Segment Usage	Valid Values	Comments
BPR01	R	H	Since all accounting information is not accessible by SD/MC, the Phase I 835 will be (H) - notification only.
BPR02	R	0	Since Phase I will only be able to support notification, this value will always be zero.
BPR03	R	C	Credit / Debit Flag Code
BPR04	R	NON	Because BPR01 = H, NON (Non-Payment Data) is used here.
BPR16	R		Date of 835. CCYYMMDD format.

Segment Name		Reassociation Trace Number	
Segment ID		TRN	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment uniquely identifies a transaction to an application	
Example		TRN*1*592003061003*1482003030*DMH~	
Element ID	Usage	Valid Values	Comments
TRN01	R	1	Trace Type Code
TRN02	R		Check or EFT Trace Number The batch number found on the EOB will be placed here.
TRN03	R	1482003030	Payer Identifier Federal Tax ID, preceded by "1"; if BPR10 is used, they must match
TRN04	R	DMH	Used to identify the appropriate State Department (DMH).

Segment Name		Receiver Identification	
Segment ID		REF	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment identifies the receiver.	
Example		REF*EV*59~	
Element ID	Usage	Valid Values	Comments
REF01	R	EV	Reference Identification Qualifier
REF02	R		Receiver ID from NM109 in the 837 Transaction

Segment Name		PRODUCTION DATE	
Segment ID		DTM	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment provides claim date information.	
Example		DTM*405*20030820~	
Element ID	Usage	Valid Values	Comments
DTM01	R	405	Reference Identification Number;
DTM02	R	20030516	This is the date SD/MC processed the claims on this 835.

Segment Name		Payer Identification	
Segment ID		N1	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		This segment identifies a Party by type of organization, name, and code	
Example		N1*PR*01~	
Element ID	Usage	Valid Values	Comments
N101	R	PR	Entity Identifier Code
N102	S	01	Payer Name; Valid Value: 01 – DMH
N103	N/A	Not used	Identification Code Qualifier
N104	N/A	Not used	Identification Code

Segment Name		**Payer Address**	
Segment ID		N3	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		This segment conveys Street Address information	
Example		N3*1600 9th STREET~	
Element ID	**Usage**	**Valid Values**	**Comments**
N301	R	1600 9th STREET	Billing Provider Address Information
N302	S		Required if Second Address Line exists

Segment Name		Payer City/State/Zip	
Segment ID		N4	
Loop ID		1000A	
Segment Usage		Required	
Segment Notes		Payer City/State/ZIP	
Example		N4*SACRAMENTO*CA*95814~	
Element ID	Usage	Valid Values	Comments
N401	R	Sacramento	City Name
N402	R	CA	State or Province Code
N403	R	95814	Postal Code

Segment Name		Payee Identification	
Segment ID		N1	
Loop ID		1000B	
Segment Usage		Required	
Segment Notes		This segment identifies the Payee in the transaction.	
Example		N1*PE*York County Care Agency*FI*956000928~	
Element ID	Usage	Valid Values	Comments
N101	R	PE	Entity Identifier Code
N102	R		Payee Name; Same name as Pay-To Provider Name from the 837. If the Pay-To Provider Loop was not sent, this will be the Billing Provider Name.
N103	R	FI	Uses "FI" until Nat'l Provider ID
N104	R		Payee Identification Code This is the Pay-To Provider ID from the 837. If the Pay-To Provider Loop was not sent, this will be the Billing Provider ID**.**

Segment Name		Header Number	
Segment ID		LX	
Loop ID		2000	
Segment Usage		Required	
Segment Notes			
Example		LX*1~	
Element ID	Usage	Valid Values	Comments
LX01	R		Assigned Number

Segment Name		Claim Payment Information	
Segment ID		CLP	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment supplies information common to all services of a claim.	
Example		CLP*1887*4*562*0**MC~	
Element ID	Usage	Valid Values	Comments
CLP01	R		Claim Submit Identifier This is the value from CLM01 on 837 (patient account number for the 837I)
CLP02	R		Claim Status Code; 4 = Denied, 13 = Suspended, 25 = Predetermination Pricing Only - No Payment. See cross walk for additional details
CLP03	R		Total Claim Charge Amount: Taken from CLM02 in 837 Transaction
CLP04	R		Claim Payment Amount. This will reflect the amount of all services on the claim.
CLP05	N/A		Patient Responsibility Amount; This will not be used to report Patient Share of Cost in Phase I. Share of Cost will be reported in Claim Supplemental Information.
CLP06	R	MC	MC = MEDICAID
CLP07	N/A		Payer Claim Control Number; Not Used
CLP08	S		Only used if adjudication changed the value from what was originally sent on the claim
CLP09	S		This is the value from CLM05-3 on the 837I. 1=Admit & Discharge Claim 2=Interim 1st Claim 3=Interim Continuing Claim 4=Interim Last Claim

Segment Name		Patient Name	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment identifies the Patient associated with a claim.	
Example		NM1*QC*1*LastName*FirstName1*MI***HN*1234567890~	
Element ID	Usage	Valid Values	Comments
NM101	R	QC	Entity Identifier Code QC=Patient
NM102	R	1	Entity Type Qualifier 1 – Person
NM103	R		Patient Last Name or Organization Name Only the first 11 letters of the last name will be transferred to the SD/MC - EOB
NM104	R		Patient First Name Only the first 3 letters of the first name will be transferred to the SD/MC - EOB
NM105	S		Patient Middle Name
NM106	N/A		CLAIM FILING INDICATOR CODE
NM107	N/A		Name Suffix
NM108	S	HN	Identification Code Qualifier
NM109	S		Patient Identifier CIN, BIC, etc. This is the value that was reported on the 837.

Segment Name		Corrected Patient / Insured Name	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		Corrected patient information for Medicaid.	
Example		NM1*74*1*****C*592091002839A~	
Element ID	Usage	Valid Values	Comments
NM101	R	74	Entity Identifier Code 74=Corrected Insured
NM102	R	1	Entity Type Qualifier 1 – Person 2 -Nonperson
NM103	R		Patient Last Name or Organization Name
NM104	R		Patient First Name
NM105	S		Patient Middle Name
NM106	N/A		Name Prefix Not Used
NM107	N/A		Name Suffix Not Used
NM108	R	C	Identification Code Qualifier; C = Insured's Changed Unique ID Number
NM109	R		Identification Code; County, approved aid, and CIN from EOB, in that order.

Segment Name		Service Provider Name	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment identifies the Rendering Provider. Required when the rendering provider is different from the Payee, which is true in most cases for SDMC. This is data related to the SDMC Provider Code, which is on the Service Facility Location in the 837P and 837I.	
Example		NM1*82*2******MC*5905~	
Element ID	Usage	Valid Values	Comments
NM101	R	82	Entity Identifier Code 82=Rendering Provider
NM102	R	2	Entity Type Qualifier 2 –Non person
NM103	N/A		Rendering Provider Last Name or Organization Name;
NM104	N/A		Rendering Provider First Name;
NM105	N/A		Rendering Provider Middle Name:
NM106	N/A		Name Prefix;
NM107	N/A		Name Suffix;
NM108	R	MC	Identification Code Qualifier; MC = Medicaid Provider Number
NM109	R		This is the SD/MC Provider Code submitted at the claim level on the 837.

Segment Name		Corrected Priority Payer Name	
Segment ID		NM1	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment identifies a third party payer.	
Example		NM1*PR*2*Medicare Part A and Part B*****PI*Z~	
Element ID	Usage	Valid Values	Comments
NM101	R	PR	PR = Payer
NM102	R	2	Entity Type Qualifier 1 – Person 2 –Non person
NM103	S		See TPL crosswalk for details – name of organization.
NM104	N/A		First Name
NM105	N/A		Middle Name
NM106	N/A	Not Used	Name Prefix
NM107	N/A	Not Used	Name Suffix
NM108	R	PI	PI = Payer Identification
NM109	R		Corrected Priority Payer ID See TPL crosswalk for details

Segment Name		Other Claim Related Information	
Segment ID		REF	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		The additional patient identifiers found on the EOB are reported here.	
Example		REF*EA*002606567~	
Element ID	Usage	Valid Values	Comments
REF01	R	EA	Reference Identification Number; EA – Medical Record Number
REF02	R		Reference Identification

Segment Name		Other Claim Related Information	
Segment ID		REF	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		The additional patient identifiers found on the EOB are reported here.	
Example		REF*SY*548909368~	
Element ID	Usage	Valid Values	Comments
REF01	R	SY	Reference Identification Number; SY – Social Security Number
REF02	R		Reference Identification

Segment Name		Other Claim Related Information	
Segment ID		REF	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		The additional patient identifiers found on the EOB are reported here.	
Example		REF*1W*596HM548909368~	
Element ID	Usage	Valid Values	Comments
REF01	R	1W	Reference Identification Number; 1W = Member Identification Number (Bene ID), EA = Medical Record Number, SY = Social Security Number. The segment will be repeated 3 times to provide all three values.
REF02	R		Reference Identification

Segment Name		CLAIM DATE	
Segment ID		DTM	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		This segment provides claim date information.	
Example		DTM*050*20030814~	
Element ID	Usage	Valid Values	Comments
DTM01	R	050	Reference Identification Number; Valid Values: 050 – Received Date 036 – Expiration Date 232 – Claim Statement Period Start 233 – Claim Statement Period End
DTM02	R		Date Received by DMH (CCYYMMDD)

Segment Name		Claim Supplemental Information	
Segment ID		AMT	
Loop ID		2100	
Segment Usage		Required	
Segment Notes		Claim Supplemental Information	
Example		AMT*F5*10~	
Element ID	Usage	Valid Values	Comments
AMT01	R	F5	Amount Qualifier Code
AMT02	R		Claim Supplemental Information Quantity Medi-Cal Patient Share of Cost Reported on the 837 AMT*F5

Segment Name		Service Payment Information	
Segment ID		SVC	
Loop ID		2110	
Segment Usage		Required	
Segment Notes		The number of SVC Segments can be >1 based on the number of services performed.	
Example		SVC*HC:H2012:HE:TG*85.5*0**0**4~	
Element ID	Usage	Valid Values	Comments
SVC01	R		Composite Medical Procedure Identifier
SVC01-01	R	HC	Product/Service ID Qualifier;
SVC01-02	R		Procedure Code; This is the procedure or revenue code on the 837P and 837I
SVC01-03	S		This is the first Modifier Reported on the procedure code from the 837P Transaction
SVC01-04	S		This is the second Modifier Reported on the procedure code from the 837P Transaction
SVC01-05	S		This is the third Modifier Reported on the procedure code from the 837P Transaction
SVC01-06	S		This is the fourth Modifier Reported on the procedure code from the 837P Transaction
SVC01-07	N/A		Procedure Code Description; Not used
SVC02	R		Line Item Charge Amount; Amount Billed
SVC03	S		Line Item Provider Payment Amount/Approved Amount
SVC04	S		NUBC Revenue Code
SVC05	R		Quantity; Units of Service Paid Count; This value will be either units of service or units of time.
SVC06	N/A		Product / Service ID; Not used
SVC07	S		Original Units of Service Quantity; Units of Service or Time Paid Count; This value is required when the value of SVC07 is different than SVC05.

Segment Name		Service Date	
Segment ID		DTM	
Loop ID		2110	
Segment Usage		Required	
Segment Notes		This segment will be sent once for single day services and twice for multi-day services.	
Example		DTM*472*20030609~	
Element ID	Usage	Valid Values	Comments
DTM01	R		Date / Time Qualifier; Valid Values: 150 – Service Period Start 151 – Service Period End 472 – Service
DTM02	R		Date; The date is expressed in CCYYMMDD Format.

Segment Name		Service Adjustment	
Segment ID		CAS	
Loop ID		2110	
Segment Usage		Situational	
Segment Notes		Adjustments reflected here correlate to error messages and transactions code errors on the EOB.	
Example		CAS*CO*42*85.5*~	
Element ID	Usage	Valid Values	Comments
CAS01	R	CO	Claim Adjustment Group Code; Valid Values: CO – Contractual Obligations OA – Other Adjustments PI – Payer Initiated Reductions Pr – Patient Responsibility
CAS02	R		Adjustment Reason Code See SDMC Error crosswalk
CAS03	R		Monetary Amount. This field contains the amount of the adjustment.

Segment Name		Service Identification	
Segment ID		REF	
Loop ID		2110	
Segment Usage		Required for 837P Claims Only	
Segment Notes		Service Identification	
Example		REF*6R*31063~	
Element ID	Usage	Valid Values	Comments
REF01	R	6R	6R = Line Item Control Number.
REF02	R		Matches number on 837P

Segment Name		Rendering Provider Information	
Segment ID		REF	
Loop ID		2110	
Segment Usage		Situational	
Segment Notes		Only use when rendering provider is specific to this service line, as would be indicated on the 837.	
Example		REF*1D*5905~	
Element ID	Usage	Valid Values	Comments
REF01	R	1D	1D = Medicaid Provider Number
REF02	R		If 1D exists in 837 then it is returned.

Segment Name		Service Supplemental Amount	
Segment ID		AMT	
Loop ID		2110	
Segment Usage		Required	
Segment Notes		This segment is used to convey information only. No Dollar Amounts are sent. This is not part of the financial balancing of an 835 transaction.	
Example		AMT*B6*20~	
Element ID	Usage	Valid Values	Comments
AMT01	R	B6	Amount Qualifier Code
AMT02	R		Monetary Amount This is the SD/MC Maximum Allowable Amount

Segment Name		Health Care Remarks Code	
Segment ID		LQ	
Loop ID		2110	
Segment Usage		Required	
Segment Notes		Remarks reflected here should be combined with the adjustment reason codes sent to correlate to error messages and transactions code errors on the EOB.	
Example		LQ*HE*MA130~	
Element ID	Usage	Valid Values	Comments
LQ01	R	HE	Code List Requirement Code
LQ02	R		Industry Code. Use for adjustments that are not specific to a particular claim or service. See SDMC Error crosswalk

Segment Name		Provider Adjustment	
Segment ID		PLB	
Loop ID		Summary	
Segment Usage		Situational	
Segment Notes		One occurrence will be generated per unique SD/MC Provider number at the service level.	
Example		PLB*5914*20031231*CS:482003030101*0~	
Element ID	Usage	Valid Values	Comments
PLB01	R		Reference Identification; SDMC Provider Number
PLB02	R		Date; Fiscal Period Date. If the Fiscal Date is not known use December 31st of this year.
PLB03-01	R	CS	Adjustment Reason Code
PLB03-02	R		Reference Identification. This is the DMH Batch Number.
PLB04	R		Monetary Amount. This amount reflects the sum of all approved amounts for services for the provider ID on the 835.

Segment Name		Transaction Set Trailer	
Segment ID		SE	
Loop ID		Summary	
Segment Usage		Required	
Segment Notes		Transaction Set Trailer Counts	
Example		SE*26*0196~	
Element ID	Usage	Valid Values	Comments
SE01	R		Number of Included Segments
SE02	R		Transaction Set Control Number. Must match the value sent in the ST02 field.

8.3. EXAMPLE OF A 835 TRANSACTION

	Interchange Control Header
1	ISA*00* *00* *ZZ*INFOTECHWEBSVCS*ZZ*C59000000000000*030930*1256*U*00401*00000636*0*P*:~
	Functional Group Header
2	GS*HP*INFOTECHWEBSVCS*C59000000000000*20030930*1256*614*X*004010X091A1~
	Transaction Set Header (835)
3	ST*835*0001~
4	BPR*H*0*C*NON**********20031001~
5	TRN*1*592003061003*1482003030*DMH~
6	REF*EV*59~
7	DTM*405*20030820~
	Payer Identification (1000A)
8	N1*PR*01~
9	N3*1600 Ninth Street~
10	N4*SACRAMENTO*CA*95814~
	Payee Identification (1000B)
11	N1*PE*York County Health Care Agency*FI*956000928~
	Header Number (2000)
12	LX*1~
	Claim Payment Information (2100)
13	CLP*1887*25*300.5*0**MC~
14	NM1*QC*1*LastName*FirstName1*MI***HN*1234567890~
15	NM1*74*1******C*596091002839A~
16	NM1*82*2******MC*5905~
17	NM1*PR*2*Medicare Part A and Part B*****PI*Z~
18	REF*EA*002606567~
19	REF*SY*548909368~
20	REF*1W*596HM548909368~
21	DTM*050*20030814~
22	AMT*F5*10~
	Service Payment Information (2110)
23	SVC*HC:H2012:HE*100.5*73.77**4~
24	DTM*472*20030609~
25	CAS*CO*42*26.73~
26	REF*6R*31063~
27	REF*1D*5905~
28	AMT*B6*73.77~
29	LQ*HE*N59~
30	SVC*HC:H2012:HE:*90*73.77**4~
31	DTM*472*20030610~
32	CAS*CO*42*16.23~
33	REF*6R*31064~
34	REF*1D*5905~

35 AMT*B6*73.77~
36 LQ*HE*N59~
37 SVC*HC:H2012:HE*110*73.77**4~
38 DTM*472*20030611~
39 CAS*CO*42*36.23
40 REF*6R*31065~
41 REF*1D*5905~
42 AMT*B6*73.77~
43 LQ*HE*N59~

Claim Payment Information (2100)

44 CLP*1234567891*25*1050.6*0**MC~
45 NM1*QC*1*LastName*FirstName2*MI***HN*1234567891~
46 NM1*74*1******C*5920998765432C~
47 NM1*82*2******MC*5905~
48 REF*EA*0872~
49 REF*SY*551732045~
50 REF*1W*5920M987654231~
51 DTM*050*20030814~
52 AMT*F5*0~

Service Payment Information (2110)

53 SVC*HC:H2011:HE*1050.6*920.7**18~
54 DTM*472*20030604~
55 CAS*CO*42*129.9~
56 REF*6R*31066~
57 REF*1D*5905~
58 AMT*B6*3.41~
59 LQ*HE*N59~

Claim Payment Information (2100)

60 CLP*31067*25*3900*2514.6*0**MC~
61 NM1*QC*1*LastName*FirstName2*MI***HN*1234567891~
62 NM1*74*1******C*5920998765432C~
63 NM1*82*2******MC*5905~
64 REF*EA*0872~
65 REF*SY*551732045~
66 REF*1W*5920M987654231~
67 DTM*050*20030814~
68 AMT*F5*0~

Service Payment Information (2110)

69 SVC*HC:H2015:HE*3900*2514.6*0100*3~
70 DTM*150*20030604~
71 DTM*151*20030607~
72 CAS*CO*42*1385.4~
73 REF*1D*5905~
74 AMT*B6*838.2~
75 LQ*HE*N59~

Summary (835)

76 PLB*5905*20031231*CS:592003065001*3656.61~

77 SE*55*0002~

Functional Group Trailer

78 GE*5*614~

Interchange Control Trailer

79 IEA*1*000000636~

9. ACKNOWLEDGEMENTS AND REPORTS

9.1. 997 FUNCTIONAL ACKNOWLEDGEMENT

A functional acknowledgment is generated to report the acceptance or rejection of a functional group, transaction set, or segment related to the receipt of an 837P/837I Claim. DMH generates an outbound 997 to acknowledge all inbound transactions that are accepted or rejected in 837 processing.

DMH validates the incoming 837 transactions by first checking the syntax of the transaction for X12 Compliance and then by validating the data against the HIPAA Implementation Guideline using the ClarEDI Product based on the data content.

If a transaction contains errors, the entire ST through SE is rejected and the rest of the transactions within ISA-IEA segment are accepted provided all data meets with the compliance rules set up by the translator and ClarEDI product.

9.2. SEGMENT AND DATA ELEMENT DESCRIPTION

This section contains a tabular representation of any segment required or situational for the State of California HIPAA implementation of the 997. Each segment table contains rows and columns describing different segment elements. These components are as follows:

- Segment Name –industry assigned segment name as identified in the 997
- Segment ID –industry assigned segment ID as identified in the 997
- Loop ID –loop within which the segment should appear
- Usage – identifies the segment as required or situational
- Segment Notes –brief description of the purpose or use of the segment
- Example –example of complete segment
- Element ID –industry assigned data element ID as identified in the 997
- Usage – identifies the data element as R-required, S-situational, or N/A-not used based on DMH guidelines
- Guide Description/Valid Values –industry name associated with the data element

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

Segment Name		Transaction Set Header	
Segment ID		ST	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes			
Example		ST*997~54321~	
Element ID	**Usage**	**Valid Values**	**Comments**
ST01	R	997	None
SE02	R	0001	Transaction Set Control Number

Segment Name		**Functional Group Response Header**	
Segment ID		AK1	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment is used to respond to the functional group information in the interchange.	
Example		AK1*HC*8215~	
Element ID	**Usage**	**Valid Values**	**Comments**
AK101	R	HC	Functional Identifier Code
AK102	R		Transaction Set Control Number

Segment Name		**Transaction Set Response Header**	
Segment ID		AK2	
Loop ID		AK2	
Segment Usage		Situational	
Segment Notes		This segment starts the transaction set acknowledgement. This segment is sent if the 837 is accepted or rejected/	
Example		AK2*837*252525~	
Element ID	**Usage**	**Valid Values**	**Comments**
AK201	R	837	Functional Identifier Code
AK201	R		Transaction Set Control Number; This data element contains the value from the ST segment of the original 837 file.

Segment Name		Data Segment Note	
Segment ID		AK3	
Loop ID		AK2/AK3	
Segment Usage		Situational	
Segment Notes		This segment reports segment/looping errors in the submitted transaction.	
Example		AK3*NM1*16*2010BA*8~	
Element ID	**Usage**	**Valid Values**	**Comments**
AK301	R	**NMI**	Segment ID Code
AK302	R		Segment Position in the Transaction Set; This data element contains the sequential position of the segment ID identified in the AK301. This count begins with 1 for the ST segment and increments by one from that point.
AK303	S		This data element identifies the loop where the erroneous segment resides.
AK304	S		This data element describes the type of error encountered.

Segment Name		Data Segment Note	
Segment ID		AK4	
Loop ID		AK2/AK3	
Segment Usage		Situational	
Segment Notes		This segment reports data element/composite errors in the submitted transaction.	
Example		AK4*9:1**67*1~	
Element ID	**Usage**	**Valid Values**	**Comments**
AK401	R		Position in Segment; This is a composite data element.
AK401-1	R		Segment Position in the Transaction Set; This data element contains the sequential position of the segment ID identified in the AK301. This count begins with 1 for the ST segment and increments by one from that point.
AK401-2	S		Component Data Element Position in Composite; This data element identifies within the composite structure where the error occurred.
AK402	S		Data Element Reference Number; This is the Data Element Dictionary reference number associated with erroneous data.
AK403	R		Data Element Syntax Error Code; Data Element Syntax Error Code; This data element describes the type of error encountered.

Segment Name		Transaction Set Response Trailer	
Segment ID		AK5	
Loop ID		AK2/AK3	
Segment Usage		Required	
Segment Notes		This segment acknowledges the transaction acceptance or rejection and any report errors.	
Example		AK5*R*5~	
Element ID	**Usage**	**Valid Values**	**Comments**
AK501	R		Transaction Set Acknowledgement Code. A – Accepted R - Rejected
AK502	R		Transaction Set Syntax Error Code;

Segment Name		Functional Group Response Trailer	
Segment ID		AK9	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		This segment acknowledges the functional group acceptance or rejection and reports the number of transaction sets originally included, received, and accepted.	
Example		AK9*R*1*1*0~	
Element ID	**Usage**	**Valid Values**	**Comments**
AK901	R		Functional Group Acknowledgement Code Values Used: A – Accepted R - Rejected
AK902	R		Number of Transaction sets included; This data element contains the value from the GE01 data element from the GE Segment of the original file being acknowledged.
AK903	R		Number of Received Transaction Sets
AK902	R		Number of Accepted Transaction Sets

Segment Name		Transaction Set Trailer	
Segment ID		SE	
Loop ID		N/A	
Segment Usage		Required	
Segment Notes		Transaction Set Trailer Counts	
Example		SE*6*54321~	
Element ID	**Usage**	**Valid Values**	**Comments**
SE01	R		Number of Included Segments
SE02	R		Transaction Set Control Number

9.3. EXAMPLES OF ACCEPTED AND REJECTED 997 TRANSACTION SETS

Scenario 1: Accepted Transaction Set

The following message shows a 997 for an accepted functional group with only one transaction set.

```
ISA*00*                                                                    *00*
*ZZ*INFOTECHWEBSVCS*ZZ*C19000000000000*030922*1945*U*00401*000000306*0*P*:
GS*FA*INFOTECHWEBSVCS*C19000000000000*20030922*1945*297*X*004010X098A1
ST*997*0295
AK1*HC*0
AK2*837*0001
AK5*A             -- A indicates an Accepted Transaction Set
AK9*A*1*1*1 -- A indicates an Accepted Functional Group
SE*6*0295
GE*1*297
IEA*1*000000306
```

Scenario 2: Rejected Transaction Set

The following message shows a 997 for a rejected functional group with only one transaction set.

```
ISA*00*                                                                    *00*
*ZZ*INFOTECHWEBSVCS*ZZ*C19000000000000*030923*1255*U*00401*000000320*0*P*:
GS*FA*INFOTECHWEBSVCS*C19000000000000*20030923*1255*311*X*004010X098A1
ST*997*0309
AK1*HC*0
AK2*837*0005
AK5*A                   --A indicates accepted Transaction set
AK2*837*0002
AK3*CLM*21*2300*8 -- CLM segment in loop 2300 has error
AK4*2*782*7
AK3*DMG*17**2
AK3*N4*16**2
AK3*N3*15**2
AK3*SE*186*837P
AK3*HL*13*2000B*3
AK5*R*5*4               --R indicates Rejected Transaction set
AK2*837*0003
AK5*A                   --R indicates accepted Transaction set
AK9*P*3*3*2
SE*17*0309
GE*1*311
IEA*1*000000320
```

10. CROSS WALK MAPPINGS & OTHER TABLES

10.1 MAPPING THE SD/MC CLAIM CODES TO THE 837P AND THE 837I

TABLE A – 837P (PROFESSIONAL) MODE OF SERVICE AND SERVICE FUNCTION CROSSWALK

Cost Reports & CSI	SD/MC Claim Service Codes			HIPAA 837 P Service Codes					
Mode of Service	Mode of Service	Service Function	Service Description	Procedure Code	Unit or Basis for Measurement Code	Procedure Modifier 1	Procedure Modifier 2	Place Of Service Code	Taxonomy Code
05	05	20-29	Psychiatric Health Facility (PHF)	H2013	Unit = day	HE			
05	05	40-49	Adult Crisis Residential	H0018	Unit = day	HE	HB, HC		
05	05	65-79	Adult Residential	H0019	Unit = day	HE	HB, HC		
10	12	20-24	Crisis Stabilization	S9484	Unit = hour	HE	TG	23	282N00000X 283Q00000X
10	12	25-29	Crisis Stabilization	S9484	Unit = hour	HE	TG	20	282N00000X 283Q00000X
10	12	81-84	Day TX Intensive Half Day	H2012	Unit = 1 hour (use 4 units)	HE	TG		282N00000X 283Q00000X
10	12	85-89	Day TX Intensive Full Day	H2012	Unit = 1 hour (use 6 units)	HE	TG		282N00000X 283Q00000X
10	12	91-94	Day TX Habilitative Half Day	H2012	Unit = 1 hour (use 4 units)	HE			282N00000X 283Q00000X
10	12	95-99	Day TX Habilitative Full Day	H2012	Unit = 1 hour (use 6 units)	HE			282N00000X 283Q00000X
15	12	01-08	Linkage/Brokerage	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	09	Linkage/Brokerage Professional IP Visit	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	282N00000X 283Q00000X
15	12	10-18 30-38 40-48 50-57	MHS	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	19, 39, 49, 59	MHS - Professional IP Visit	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	282N00000X 283Q00000X
15	12	58	TBS	H2019	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	60-68	Medication Support	H2010	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X 283Q00000X
15	12	69	Medication Support-Professional IP Visit	H2010	Unit = 15 minutes (Bill in one-minute increments)[1]	HE		21, 51	282N00000X 283Q00000X

Cost Reports & CSI	SD/MC Claim Service Codes			HIPAA 837 P Service Codes					
Mode of Service	Mode of Service	Service Function	Service Description	Procedure Code	Unit or Basis for Measurement Code	Procedure Modifier 1	Procedure Modifier 2	Place Of Service Code	Taxonomy Code
15	12	70-78	Crisis Intervention	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			282N00000X, 283Q00000X
15	12	79	Crisis Intervention-Professional IP Visit	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	282N00000X 283Q00000X
10	18	20-24	Crisis Stabilization	S9484	Unit = hour	HE	TG	23	
10	18	25-29	Crisis Stabilization	S9484	Unit = hour	HE	TG	20	
10	18	81-84	Day TX Intensive Half Day	H2012	Unit = 1 hour (use 4 units)	HE	TG		
10	18	85-89	Day TX Intensive Full Day	H2012	Unit = 1 hour (use 6 units)	HE	TG		
10	18	91-94	Day TX Habilitative Half Day	H2012	Unit = 1 hour (use 4 units)	HE			
10	18	95-99	Day TX Habilitative Full Day	H2012	Unit = 1 hour (use 6 units)	HE			
15	18	01-08	Linkage/Brokerage	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	09	Linkage/Brokerage Professional IP Visit	T1017	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	
15	18	10-18 30-38 40-48 50-57	MHS	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	19, 39, 49, 59	MHS - Professional IP Visit	H2015	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	
15	18	58	TBS	H2019	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	60-68	Medication Support	H2010	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	69	Medication Support-Professional IP Visit	H2010	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	
15	18	70-78	Crisis Intervention	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE			
15	18	79	Crisis Intervention-Professional IP Visit	H2011	Unit = 15 minutes (Bill in one-minute increments) [1]	HE		21, 51	

1 Refer to the Table B "Minute to Units Conversion" for instructions on completing the units field.

Procedure Code Definitions (HCPCS)	
H0018	Behavioral Health: Short-Term Residential. Non-hospital - Without Room & Board per diem.
H0019	Behavioral Health: Long term Residential Non-Acute, non-medical, usually longer than 30 days.
H2010	Comprehensive Medication Services - per 15 minutes
H2011	Crisis Intervention - per 15 minutes
H2012	Behavioral Health Day Treatment - per 1 hour
H2013	Psychiatric Health Facility - per diem
H2015	Comprehensive Community Support - per 15 minutes
H2019	Therapeutic Behavioral Service - per 15 minutes
S9484	Crisis Intervention Mental Health Service - Per Hour
T1017	Targeted Case Management - per 15 minutes

Modifier Code Definitions	
HB	Adult Program, Non-Geriatric
HC	Adult Program Geriatric
HE	Mental Health Program
TG	Complex/High Technical Level of Care

Place Of Service Code Definitions	
20	Urgent Care
21	Hospital Inpatient
23	Hospital ER
51	Inpatient Psychiatric Facility

Taxonomy Code Definitions	
282N00000X	General Hospital
283Q00000X	Psychiatric Hospital

Mode of Service Definitions Short-Doyle / Medi-Cal Mode Definitions	
05	24-Hour non-Hospital Services
12	Outpatient Hospital Services
18	Non-Residential Rehabilitative Treatment

Cost Reports & CSI Mode of Service Definitions	
05	24-Hour Services
10	Day Services
15	Outpatient Services

NOTE: ClarEDI requires Procedure Modifiers to be filled in starting with Modifier 1, then 2, 3, and 4. That is, if Procedure Modifier fields1 and 4 are filled with valid values and Procedure Modifier fields 2 and 3 are blank, ClarEDI will reject the record.

TABLE B - MINUTE TO UNITS CONVERSION

To convert minutes to units of 15-minute increments, multiply each minute of service by 1/15 (0.066667) and round to two decimal places. The translator will multiply the resulting units by 15 and round to zero decimal places to obtain the minutes.

County Function			State Function	
Col 1	Col 2	Col1*Col2 Rounded	Col 4	Col3*Col4 Rounded
Minutes to Units			Units to Minutes	
Minutes	Multiplication Factor	Units	Multiplication Factor	Minutes
1	0.066667	0.07	15	1
2	0.066667	0.13	15	2
3	0.066667	0.20	15	3
4	0.066667	0.27	15	4
5	0.066667	0.33	15	5
6	0.066667	0.40	15	6
7	0.066667	0.47	15	7
8	0.066667	0.53	15	8
9	0.066667	0.60	15	9
10	0.066667	0.67	15	10
11	0.066667	0.73	15	11
12	0.066667	0.80	15	12
13	0.066667	0.87	15	13
14	0.066667	0.93	15	14
15	0.066667	1.00	15	15
16	0.066667	1.07	15	16
17	0.066667	1.13	15	17
18	0.066667	1.20	15	18
19	0.066667	1.27	15	19
20	0.066667	1.33	15	20
25	0.066667	1.67	15	25
30	0.066667	2.00	15	30
40	0.066667	2.67	15	40
45	0.066667	3.00	15	45
50	0.066667	3.33	15	50
60	0.066667	4.00	15	60
90	0.066667	6.00	15	90
120	0.066667	8.00	15	120
180	0.066667	12.00	15	180
240	0.066667	16.00	15	240

TABLE C – 837I (INSTITUTIONAL) SERVICE CODE CROSSWALK

Cost Reports & CSI	SD/MC Claim Service Codes			HIPAA 837 I Service Codes				
Mode of Service	**Mode of Service**	**Service Function**	**Service Description**	**Revenue Code**	**Unit or Basis for Measurement Code**	**Procedure Code**	**Procedure Modifier 1**	**Procedure Modifier 2**
05	07	10-18	Hospital Inpatient	0100	DA(day)	H2015	HE	
05	07	19	Hospital Inpatient - Administrative Day	0101	DA(day)	H0046	HE	
05	08	10-18	Hospital Inpatient - Psychiatric Hospital under age 21	0100	DA(day)	H2015	HE	HA
05	08	19	Hospital Inpatient - Administrative Day - Psychiatric Hospital under age 21	0101	DA(day)	H0046	HE	HA
05	09	10-18	Hospital Inpatient - Psychiatric Hospital over age 64	0100	DA(day)	H2015	HE	HC
05	09	19	Hospital Inpatient - Administrative Day - Psychiatric Hospital over age 64	0101	DA(day)	H0046	HE	HC

HIPAA Service Code Definitions	
Procedure Code Definitions (HCPCS)	
H2015	Mental Health Service
H0046	Mental Health Service Not Elsewhere Classified

Modifier Code Definitions	
HA	Child/Adolescent Program
HB	Adult Program, Non-Geriatric
HC	Adult Program Geriatric
HE	Mental Health Program

Revenue Code Definitions	
0100	Room and Board, Plus ancillaries
0101	Room and Board only

Short-Doyle/Medi-Cal Mode Definitions	
07	Inpatient Hospital Services
08	Psychiatric Hospital (Inpatient) - Under 21
09	Psychiatric Hospital (Inpatient) - 65 or Over

Cost Reports & CSI Mode of Service Definitions	
05	24-Hour Services

NOTE: ClarEDI requires Procedure Modifiers to be filled in starting with Modifier 1, then 2, 3, and 4. That is, if Procedure Modifier fields1 and 4 are filled with valid values and Procedure Modifier fields 2 and 3 are blank, ClarEDI will reject the record.

TABLE D - CROSSOVER INDICATOR CROSSWALK

SD/MC Code	SD/MC Code Description	837P or 837I Field/Name 1	Value 1	837P or 837I Field/Name 2	Value 2
Blank	No Medicare or other health coverage	CLM07/Medicare Assignment Code	Any valid value except “C”	Loop 2320 is not present	
H	Non-Medicare certified provider	CLM07/Medicare Assignment Code	C	Loop 2320 is not present	
N	Medicare covered recipient, however either Medicare denied the claim or the claim is for services that Medicare does not cover.	Loop 2320, SBR09/Claim Filing Indicator Code	MB	Loop 2320, AMT02/COB Allowed Amount	0 (Zero)
P	Other health coverage	Loop 2320, SBR09/Claim Filing Indicator Code	10, 11, 12, 13, 14, 15, 16, AM, BL, CH, CI, DS, HM, LI, LM, OF, TV, VA, WC, ZZ	Loop 2320, AMT02/COB Payer Paid Amount (837P)or Prior Payer Payment (837I)	Greater than zero.
X	Medicare coverage	Loop 2320, SBR09/Claim Filing Indicator Code	MB	Loop 2320, AMT02/COB Payer Paid Amount (837P)or Prior Payer Payment (837I)	Greater than zero.

TABLE E - DUPLICATE PAYMENT OVERRIDE CODE CROSSWALK

SD/MC Code	SD/MC Code Description	Procedure Modifier	Modifier Description
Y	Override duplicate billing edit	59	Distinct Procedural Service
Y	Override duplicate billing edit	76	Repeat Procedure by Same person
Y	Override duplicate billing edit	77	Repeat Procedure by Different person
Blank	Do not override duplicate billing edit		

If a procedure modifier of 59, 76, or 77 appears at the service line the "Translator" will put a "Y" in the "Duplicate Payment Override" field on the SD/MC claim legacy system.

TABLE F - DELAY REASON CODE CROSSWALK

SD/MC Late Billing Override Code	Description	HIPAA Delay Reason Code	HIPAA Descriptions
A	Patient or legal representative's failure to present Medi-Cal identification	1	Proof of Eligibility Unknown or Unavailable
B	Billing involving other coverage including, but not limited to Medicare, Ross-Loos or CHAMPUS	7	Third Party Processing Delay
C	Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county.	8	Delay in Eligibility Determination
D	Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable.	4, 11	4=Delay in Certifying Provider 11=Other
E	Special circumstances that cause a billing delay such as a court decision or fair hearing decision.	10	Administrative Delay in Prior Approval Process.
F	Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC).	2	Litigation
Blank	Do not override late billing		

This section helps in uniquely translating the Short-Doyle/Medi-Cal System (SD/MC) codes to HIPAA compliant codes and vice versa.

TABLE G - MAPPING THE SD/MC EOB CODES TO THE 835

Sort Key (Claim Adjudication Type)		Claim Status Code	
A	Approved Claim	25	Predetermination Pricing Only, No payment
D	Denied Claim	4	Denied
G	Aged Suspended Claim	4	Denied
S	Suspended Claim	13	Suspended

If at least one service on a claim is approved, code "25" will be used. Review the service level information to determine if any lines have been suspended or denied.

If all services have been denied, either due to edits (D) or aging (G), code "4" will be used.

If all services have been suspended, code "13" will be used.

TABLE H - THIRD PARTY LIABILITY INDICATOR CROSSWALK

SDMC EOB Value	835 Value	Value Description
A	AC	Any Carrier - Pay and Chase
C	CH	CHAMPUST Prime HMO
F	FM	Medicare HMO
K	KA	Kaiser
L	LD	Dental Only Policies
P	PH	PHP/HMOs or EPO (Exclusive Provider Option)
V	VA	Variable - any carrier other than the above, includes multiple coverage
9	9H	Healthy Families Program
*	XM	Medicare Part A only
#	YM	Medicare Part B only
$	ZM	Medicare Part A and Part B
N	n/a*	None
O	n/a*	Override
Blank	n/a*	No Medicare and No TPL/OHC
M	**MU**	Two or more carriers
X	**BS**	Blue Shield
Z	**BC**	Blue Cross
B	**BD**	Blue Cross
D	**PR**	Prudential
E	**AE**	Aetna
G	**GA**	General American
H	**MO**	Mutual of Omaha
I	**ML**	Metropolitan Life
J	**JH**	John Hancock
S	**BT**	Blue Shield
T	**TR**	Travelers
U	**CG**	Connecticut General/Equicor/Cigna
W	**GW**	Great West Life
2	**PL**	Provident Life and Accident
3	**PF**	Principal Financial Group
4	**PM**	Pacific Mutual Life
5	**AH**	Alta Health Strategies
6	**AA**	AARP
8	**NY**	New York Life

* - These values will not cause data to be populated on the 835.

TABLE I - TRANSACTION CODE DENIAL REASON ERROR CODE CROSSWALK

SD/MC Error Code	SD/MC Error Message	Adjustment Group	Adjustment Reason	Remarks Code	Comments
C	Unprocessable, invalid claim ID	CO	16	MA130	
D	Unprocessable, duplicate claim ID	CO	18	MA130	
F	Failed Edits (Approve/Deny) County Option	CO	A1	MA130	
N	Deny claim with non-Title XIX determination	CO	31	MA130	
O	Unprocessable, invalid override code	CO	138	MA130	
R	Unprocessable, Receipt date error		n/a		Will be generated by state.
S	Unprocessable, duplicate claim ID on	CO	18	MA130	

	Suspense				
T	Deny claim with tape submission error		n/a		This is not applicable to HIPAA transactions.
X	County requested denial of claim on suspense	OA	A1	MA130	
Blank	Claim denied after 97 days on suspense	CO	B5	MA130	

TABLE J - SD/MC ERROR CODES CROSSWALK

SD/MC Error Codes Crosswalk

SD/MC Error	SD/MC Message	Error Field Indicators	Adjustment Group	Adjustment Reason	Remark Code	Translator Edit	Comments
01	Data element is BLANK	203-204 Gender	CO	31	MA39	Translator	
01	Data element is BLANK	205-206 DOB year	CO	31	MA38	Translator	
01	Data element is BLANK	207-208 Service YYYYMM	CO	B18	MA66	Translator	
01	Data element is BLANK	211-212 Mode of Service	CO	B7	M51	Translator	
01	Data element is BLANK	215-216 Service Function	CO	B7	M51	Translator	
01	Data element is BLANK	221-222 Total Billed Amount	CO	16	M54	Translator	
01	Data element is BLANK	223-224 Claim For Date Claim Submitted	CO	16	M58	Translator	
01	Data element is BLANK	229-230 Race/Ethnicity				N/A	Value will be populated from MEDS.
02	Not a valid date	205-206 DOB year	CO	31	MA38	Translator	
02	Not a valid date	207-208 Service YYYYMM	CO	16	MA66	Translator	
02	Not a valid date	231-232 Service/Treatment Date	CO	16	MA66	Translator	
03	Invalid code	199-200 Crossover Indicator	CO	16	MA85		
03	Invalid code	201-202 Welfare ID	CO	31	MA61		
03	Invalid code	203-204 Gender	CO	31	MA39	Translator	
03	Invalid code	209-210 Provider Code	CO	B7	M57		
03	Invalid code	211-212 Mode of Service	CO	B7	M51	Both	
03	Invalid code	215-216 Service Function	CO	B7	M51	Both	
03	Invalid code	229-230 Race/Ethnicity				N/A	
03	Invalid code	233-234 Discharge Indicator	CO	16	N50		
03	Invalid code	235-236 Diagnosis	CO	16	M81	Translator	
04	Late submission	207-208 Service YYYYMM	CO	29			
05	Not valid day	231-232 Service/Treatment Date	CO	16	MA66	Translator	
06	Not numeric	205-206 DOB year	CO	31	MA66	Translator	
06	Not numeric	207-208 Service YYYYMM	CO	16	MA66	Translator	
06	Not numeric	209-210 Provider Code	CO	B7	M57		
06	Not numeric	211-212 Mode of Service	CO	B7	M51	Translator	
06	Not numeric	217-218 Units of Time	CO	16	N59	Translator	
06	Not numeric	219-220 Units of Service	CO	16	N59	Translator	
06	Not numeric	221-222 Billed Amount	CO	16	M54	Translator	
06	Not numeric	227-228 Admit Date	CO	16	MA40	Translator	
06	Not numeric	231-232 Service/Treatment Date	CO	16	MA66	Translator	
07	Zero Claimed	217-218 Units of Time	CO	16	M53		
07	Zero Claimed	221-222 Billed Amount	CO	16	M54		
08	Mode not authorized	211-212 Mode of Service	CO	B7	N65		
08	Mode not authorized	209-210 Provider Code	CO	B7	MA129		
09	Ineligible in month and year	201-202 Welfare ID	PR	26	N59		
09	Ineligible in month and year	207-208 Service YYYYMM	PR	26	N59		
09	Ineligible in month and year	209-210 Provider Code	CO	B7	MA129		

SD/MC Error Codes Crosswalk

SD/MC Error	SD/MC Message	Error Field Indicators	Adjustment Group	Adjustment Reason	Remark Code	Translator Edit	Comments
10	Conflicts with eligibility file	199-200 Crossover Indicator	CO	16	MA85		
10	Conflicts with eligibility file	203-204 Gender	CO	31	MA21		
10	Conflicts with eligibility file	205-206 DOB year	CO	31	MA38		
10	Conflicts with eligibility file	225-226 Name	CO	31	MA21		
11	Not on eligibility file.	201-202 Welfare ID	PR	31	N59		
12	Not on DHS provider file	209-210 Provider Code	PI	B7	M57		
13	Program not authorized in month and year	207-208 Service YYYYMM	CO	B7	N56		
13	Program not authorized in month and year	209-210 Provider Code	CO	B7	MA129		
13	Program not authorized in month and year	211-212 Mode of Service	CO	B7	N56		
14	Mode not authorized in month and year	207-208 Service YYYYMM	CO	B7	N56		
14	Mode not authorized in month and year	209-210 Provider Code	CO	B7	MA129		
14	Mode not authorized in month and year	211-212 Mode of Service	CO	B7	N56		
15	No secondary match	201-202 Welfare ID	CO	31	N59		
16	Service date greater than receipt date.	207-208 Service YYYYMM	CO	110	N59		
17	Healthy Families hold period.	201-202 Welfare ID	CO	16	M16		Counties receiving this combination should review DMH Information Letter 98-14 for additional information.
17	Healthy Families hold period.	207-208 Service YYYYMM	CO	16	M16		Counties receiving this combination should review DMH Information Letter 98-14 for additional information.
18	Claim too old for eligibility check	201-202 Welfare ID	CO	31	N1		
19	Invalid Service Function Code	215-216 Service Function	CO	B7	N65	Both	
20	Units of service are not less than or equal to the units of time	217-218 Units of Time	CO	16	M53		
20	Units of service are not less than or equal to the units of time	219-220 Units of Service	CO	16	M53		
21	Invalid drug code	235-236 Diagnosis	CO	11	MA63		
22	Date range not allowed	231-232 Service/Treatment Date	CO	16	N74		
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	197-198 Duplicate	CO	119	M86		

SD/MC Error Codes Crosswalk

SD/MC Error	SD/MC Message	Error Field Indicators	Adjustment Group	Adjustment Reason	Remark Code	Translator Edit	Comments
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	217-218 Units of Time	CO	119	M53		
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	219-220 Units of Service	CO	119	M53		
24	To date is greater than from date.	231-232 Service/Treatment Date	CO	16	MA31		
25	Units not equal to days.	217-218 Units of Time	CO	16	M53		
25	Units not equal to days.	219-220 Units of Service	CO	16	M53		
25	Units not equal to days.	221-222 Billed Amount	CO	42	M54		
25	Units not equal to days.	233-234 Discharge Indicator	CO	16	M53		
26	Duplicate Service - No Override	197-198 Duplicate	CO	18	M86		
27	Multiple Service - Override OK	197-198 Duplicate	CO	18	M80		
28	Greater than two outpatient services	197-198 Duplicate	CO	119	N59		
29	Service Function Not Authorized	215-216 Service Function	CO	B7	N65		
30	Service Function Not Authorized in month and year	215-216 Service Function	CO	B7	N65		
31	Medicare Coverage Part ____, HIC # _____ __	199-200 Crossover Indicator	CO	16	MA85		
31	Medicare Coverage Part ____, HIC # _____ __	221-222 Billed Amount	CO	16	MA85		
32	Other Coverage Indicator ____	199-200 Crossover Indicator	CO	16	MA92		
32	Other Coverage Indicator ____	221-222 Billed Amount	CO	16	MA92		
33	Claims less than two days of LAAM dose	197-198 Duplicate	CO	B5	N14		
34	Dollars greater than allowed	197-198 Duplicate	CO	18	N20		
34	Dollars greater than allowed	217-218 Units of Time	CO	42	N14		
34	Dollars greater than allowed	219-220 Units of Service	CO	42	N14		
34	Dollars greater than allowed	221-222 Billed Amount	CO	42	N14		
35	Two doses in one day not allowed	197-198 Duplicate	CO	119	M86		

Table K – Crosswalk 837P to SD/MC Mode of Service and Service Functions

Table K describes how 837 revenue/procedure codes, modifiers, place of service, provider taxonomy, and units will be used to create the current Short-Doyle/Medi-Cal Mode of Service and Service Function Codes that will be used for claim processing and how they appear on the EOB.

HIPAA Procedure, Modifier, Place of Service, and Taxonomy Codes						SD/MC Claim	
SV101-2 (Procedure Code)	SV101-3 (Modifier-1)	SV101-4 (Modifier-2)	SV104 (Units)	SV105 (Place of Service)	PRV03 (Provider Taxonomy)	Mode of Service	Service Function
H2013	HE					05	20
H0018	HE	HB or HC				05	40
H0019	HE	HB or HC				05	65
S9484	HE	TG		23	282N00000X or 283Q00000X	12	20
S9484	HE	TG		20	282N00000X or 283Q00000X	12	25
H2012	HE	TG	4		282N00000X or 283Q00000X	12	81
H2012	HE	TG	6		282N00000X or 283Q00000X	12	85
H2012	HE		4		282N00000X or 283Q00000X	12	91
H2012	HE		6		282N00000X or 283Q00000X	12	95
T1017	HE				282N00000X or 283Q00000X	12	01
T1017	HE			21 or 51	282N00000X or 283Q00000X	12	09
H2015	HE				282N00000X or 283Q00000X	12	30
H2015	HE			21 or 51	282N00000X or 283Q00000X	12	39
H2019	HE				282N00000X or 283Q00000X	12	58

Table K cont.

HIPAA Procedure, Modifier, Place of Service, and Taxonomy Codes						SD/MC Claim	
SV101-2 (Procedure Code)	SV101-3 (Modifier-1)	SV101-4 (Modifier-2)	SV104 (Units)	SV105 (Place of Service)	PRV03 (Provider Taxonomy)	Mode of Service	Service Function
H2010	HE				282N00000X or 283Q00000X	12	60
H2010	HE			21 or 51	282N00000X or 283Q00000X	12	69
SV101-2 (Procedure Code)	SV101-3 (Modifier-1)	SV101-4 (Modifier-2)	SV104 (Units)	SV105 (Place of Service)	PRV03 (Provider Taxonomy)	Mode of Service	Service Function
H2011	HE				282N00000X or 283Q00000X	12	70
H2011	HE			21 or 51	282N00000X or 283Q00000X	12	79
S9484	HE	TG		23		18	20
S9484	HE	TG		20		18	25
H2012	HE	TG	4			18	81
H2012	HE	TG	6			18	85
H2012	HE		4			18	91
H2012	HE		6			18	95
T1017	HE					18	01
T1017	HE			21 or 51		18	09
H2015	HE					18	30
H2015	HE			21 or 51		18	39
H2019	HE					18	58
H2010	HE					18	60
H2010	HE			21 or 51		18	69
H2011	HE					18	70
H2011	HE			21 or 51		18	79

TABLE L – CROSSWALK 837I TO SD/MC MODE AND SERVICE FUNCTIONS

Table L describes how 837 revenue/procedure codes, modifiers, place of service, provider taxonomy, and units will be used to create the current Short-Doyle/Medi-Cal Mode of Service and Service Function Codes that will be used for claim processing and how they appear on the EOB.

HIPAA Revenue, Procedure, and Modifier Codes				SD/MC Claim	
SV201 (Revenue Code)	SV202-2 (Procedure Code)	SV202-3 (Modifier-1)	SV202-4 (Modifier-2)	Mode of Service	Service Function
0100	H2015	HE		07	10
0101	H0046	HE		07	19
0100	H2015	HE	HA	08	10
0101	H0046	HE	HA	08	19
0100	H2015	HE	HC	09	10
0101	H0046	HE	HC	09	19

TABLE M – TRANSLATOR ERRORS (837) LIST

#	SDMC Field Name	Value Required/Expected	Value Found	Category	Resolution	Error Message
1	Claim ID - Claim Type	ADP/DMH	Correct value not found	FATAL	Reject the ST-SE segment	The value 'A' was not found for the Claim Type, instead found xxxxx … Transaction Aborted
2	Claim ID - Provider Code	4 digit code	No code found at any level	FATAL	Reject the ST-SE segment	The provider code was not found or was of invalid length … Transaction Aborted
3	Claim ID - Provider Code	4 digit code	Code found but has invalid length (e.g. > 4 digits)	FATAL	Reject the ST-SE segment	The provider code was not found or was of invalid length … Transaction Aborted
4	Claim ID - Provider Code	4 digit code	Codes in 2300 and 2400 loops don't match	INFO	use code from 2400 loop	Provider Code Mismatch : 2300 code - xxxx , 2400 code - xxxx
5	Claim ID - Claim Serial	5 digit code	No code found	FATAL	Reject the ST-SE segment	The claim serial number was not found ... Transaction Aborted
6	Program Code	"01" for DMH, 20 or 25 for ADP	No Value Found or Incorrect Value Found	FATAL	Reject the ST-SE segment	Invalid program code… Transaction Aborted
7	Program Code/Mode of Service	one result from database query	No code translation is found	FATAL	Reject the ST-SE segment	No code crosswalk found… Transaction Aborted
8	Program Code/Mode of Service	one result from database query	Multiple translations are found	FATAL	Reject the ST-SE segment	Multiple code crosswalks found. Transaction Aborted
9	Patient Name	last and first names (total 14 chars)	Last or First Name greater than the required number of characters	INFO	Use whole Last Name or first 11 Characters of Last Name and 3 characters of First Name	Patient Name truckcated to fit the 14 character field.
10	Patient record number	<= 9 characters long	Longer than 9 characters	INFO	Use the first 9 characters	Patient Record number has been truncated to fit the 9 character field.
11	Beneficiary ID	<= 14 characters long	longer than 14 characters	FATAL	Reject the ST-SE segment	Beneficiary ID length is too long, transaction aborted.
12	Service first and last dates	Must be within the same month and year.		FATAL	Reject the ST-SE segment	Claim cannot cross months and years, transaction aborted
13	Units of Time (DMH only)	4 digit code needs to be populated in units of time field	a value grater than 9999	FATAL	Reject the ST-SE segment	Invalid Units of Time, transaction aborted.
14	Units of Service (DMH only)	3 digit code needs to be populated in units of service field	SV104 rounded value is greater than 999	FATAL	Reject the ST-SE segment	Invalid Units of Service, transaction aborted.
15	Total Billed Amount	a double value	Value greater than 8 characters long	FATAL	Reject the ST-SE segment	Invalid length of Total Amount Billed, transaction aborted.

16	Late Billing Override Code	specific 2-digit codes	No code translation found in database	FATAL	Reject the ST-SE segment	Invalid Late Billing Override Code, transaction aborted.
17	Late Billing Override Code	specific 2-digit codes	Multiple code translation found in database	FATAL	Reject the ST-SE segment	Invalid Late Billing Override Code, transaction aborted.
18	Crossover indicator	2 digit code	SBR09 is not from the list of valid codes	FATAL	Reject the ST-SE segment	No value or unknown value found, transaction aborted.

TABLE N – 835 CODE DEFINITIONS

835 Code Definitions

Claim Status Code - See 835, pg. 90-91 - This must be placed at the claim level.

Code	Description
4	Denied
13	Suspended
25	Predetermination Pricing Only - No Payment

Claim Adjustment Group Code See 835, pg. 97 or 150

Code	Description
CO	Contractual Obligations
OA	Other Adjustments
PI	Payor Initiated Reductions
PR	Patient Responsibility

Health Care Claim Adjustment Reason Codes - These codes can be used multiple times under a given Claim Adjustment Group Code

Code	Description
11	Diagnosis inconsistent with procedure
16	Claim lacks info for adjudication. See Remarks Codes.
17	Unidentified Error
18	Duplicate claim/service
26	Expenses incurred prior to coverage
29	The time limit for filing has expired
31	Claim denied as patient cannot be identified as our insured
42	Charges exceed our fee schedule or maximum allowable amount
110	Billing date predates service date
119	Benefit maximum for this time period has been reached.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
A1	Claim Denied charges
A2	No error, but it reduces the total amount billed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.

Remittance Advice Remark Codes - Used in remittance advice to relay informational messages that cannot be expressed with a claims adjustment reason code.

Code	Description
M16	Please see the letter of (date) for further information. (The letter number and date must be supplied).
M51	Missing/incomplete/invalid procedure code(s) and/or rates.
M53	Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.
M54	Did not complete or enter the correct charges for services rendered.
M57	Incomplete/invalid provider number
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

M63	We do not pay for more than one of these on the same day.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	Patient's diagnosis code(s) is truncated, incorrect, or missing; you are required to code to the highest level of specificity
MA21	SSA records indicate mismatch with name and sex
MA31	Incomplete/invalid beginning and ending dates of the period billed
MA38	Incomplete/invalid patient's birth date
MA39	Incomplete/invalid patient's sex
MA40	Incomplete/invalid admission date
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number
MA63	Incomplete/invalid principle diagnosis code
MA66	Incomplete/invalid principle procedure code and/or date
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
MA92	Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information
MA129	This provider was not certified for this procedure on this date of service.
MA130	Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
N20	Service not payable with other service rendered on the same date.
N50	Missing/incomplete/invalid discharge information.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N59	Please refer to your provider manual for additional program and provider information.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month

11. HELPFUL HIPAA TESTING TIPS

11.1 UNIQUE CLAIM ID REQUIREMENTS (FOR THE TRANSLATOR AND FOR THE SD/MC SYSTEM)

Some information from the 837 messages on each service line is stored in a pass-through database to be used when generating the 835 for the corresponding service lines.

To uniquely identify each service line in the Translator:

837P uses the Line Item Control Number (loop 2400)

Line Item Control Number should be created as explained below:

A) The Claim ID Serial Number (characters 6 through 10) maps to the Line Item Control Number characters 1 through 5.

B) County Use 1 maps to the Line Item Control Number characters 6 through 20.

C) County Use 2 maps to the Line Item Control Number characters 21 through 23.

837I uses the Patient Account Number (loop 2300) (Also note that an 837I must have only ONE service line per CLM)

Patient Account Number should be created as explained below:

A) The Claim ID Serial Number (characters 6 through 10) maps to the Patient Account Number characters 1 through 5.

B) County Use 1 maps to the Patient Account Number characters 6 through 20.

C) County Use 2 maps to the Patient Account Number characters 21 through 23.

For an 837(HIPAA) file to be converted into a PRO (PROPRIETARY) file, the translator expects Line Item Control Number and Patient Account Number fields to be unique in 837 file.

For SD/MC to process claims, it expects Claim IDs (the first 10 characters in the proprietary format) to be unique.

CLAIM ID in Proprietary format claim

Column	Value	Comment
1	A or H	
2 – 5	Provider Code	
6 – 10	Claim Serial Number	5 digit sequentially changing number within each provider code (each provider code has its own series)

To have the Claim IDs unique in the PRO file created from the 837 file, make sure that claims under one provider do not repeat claim serial numbers.